

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18332														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
Item 6 Film 408 1/6/69 kk														
CERTIFICATE OF DEATH														
18345														
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR M					
BERTHA			SOPHIA			ASENDORF			Dec. 28 1968					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
Female		White		Aug. 30, 1883			85 84							
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
Maryland			U. S. A.						Washington					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Williamsport			Homewood Church Home			Housewife			Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER		
Maryland			Baltimore			Baltimore			YES			2128 W. Lexington St.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
John			Sauer			Sophia			Wagner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
no			--			212-09-1264B			Mark G. Wagner, Supt., 2750 Va. Ave			Williamsport, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive CV Dis</u> 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443X														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 8-15-66 19 to 12-28 1968, that (I) (we) last saw the deceased alive on 12-26 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Robert P. Conrad						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12-29-68					
22d. PHYSICIAN'S NAME (Type) Robert P. Conrad						22e. ADDRESS 137 W. Washington Hagerstown, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			12/21/68			Loudon Park Cemetery			Baltimore, Md.					
24. FUNERAL DIRECTOR Andrew K. Coleman Funeral Home, Inc.						25a. REC'D BY REGISTRAR DEC 31 1968			25b. REGISTRAR'S SIGNATURE Charles Judge					

1945

Dec. 21 1945

Washington

Office

Central

Mr. E. A. Tamm

Mr. Clegg

Mr. Glavin

Mr. Ladd

Mr. Nichols

Mr. Rosen

Mr. Tracy

Mr. Carson

Mr. Egan

Mr. Gurnea

Mr. Hendon

Mr. Jones

Mr. Quinn

Mr. Nease

Mr. Gandy

Mr. Harbo

Mr. Mohr

Mr. Pennington

Mr. E. A. Tamm, U.S. Supreme Court Building, Washington, D.C.

cc

Mr. E. A. Tamm, U.S. Supreme Court Building, Washington, D.C.

Mr. E. A. Tamm, U.S. Supreme Court Building, Washington, D.C.

Dec 21 1945

Mr. E. A. Tamm, U.S. Supreme Court Building, Washington, D.C.

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MEDICAL CERTIFICATION

18323										18346														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print) LILLIE					First MAE Middle ATKINSON Last					2a. DATE OF DEATH Month DECEMBER Day 29 Year 68					2b. HOUR M									
3. SEX FEMALE					4. RACE WHITE					5. DATE OF BIRTH MAY 26, 1896					6. AGE (In years lost birthday) 72 YRS.					IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 				
7a. BIRTHPLACE (State or foreign country) ALABAMA					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH WASHINGTON Md.									
10. CITY OR TOWN OF DEATH HAGERSTOWN					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON COUNTY HOSP.					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CLERICAL WORK					12b. KIND OF BUSINESS OR INDUSTRY OFFICE									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND					13b. COUNTY WASHINGTON					13c. CITY OR TOWN HAGERSTOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 2118 HILLDALE ROAD				
14. FATHER'S NAME First JAMES Middle FLEMING Last					15. MOTHER'S MAIDEN NAME First LILLIE Middle HAYES Last																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. 419-30-3008A					17. INFORMANT MRS PAUL WINN 2118 Address HILLDALE RD. HAGERSTOWN, MARYLAND														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 4201 (b) Coronary sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardio Dis. 34 yrs PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertensive cardio Dis. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 1-2 yrs																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State 														
22a. I certify that (I) (this hospital) attended the deceased from 1 Sept. 1966 to date , 19 66 , that (I) (we) last saw the deceased alive on 3 Nov. 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE Richard T. Binford, M.D.										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 12/30/68									
22d. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M.D.										22e. ADDRESS 1135 POTOMAC AVE., HAGERSTOWN, MD.														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL-REMOVAL					23b. DATE 1/2/69					23c. NAME OF CEMETERY OR CREMATORY FOREST HILL CEMETERY					23d. LOCATION (City or Town) (County) (Store) BIRMINGHAM, JEFFERSON, ALA.									
24. FUNERAL DIRECTOR Charles M. Rausen										ADDRESS HAGERSTOWN, MARYLAND					25a. REC'D BY REGISTRAR JAN 2 1969					25b. REGISTRAR'S SIGNATURE Charles Judge				

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in between item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
183347									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
NELSON RANDALL BARNES						DEC. 17 1968			6:28 M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
MALE	WHITE	OCT. 28, 1915	53 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year	2d. HOUR
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				WASHINGTON Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
HAGERSTOWN			17 N MULBERRY ST.			COOK			RESTAURANT
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?
MARYLAND			WASHINGTON			HAGERSTOWN			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last			13e. STREET AND NUMBER			
DUDLEY N BARNES			MARY E KREITZ			17 N. MULBERRY ST.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
YES			214-09-9682			DUDLEY P BARNES HAGERSTOWN, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF pulmonary embolism, secondary branch of left pulmonary artery and broncho-									1-2 days
(b) DUE TO, OR AS A CONSEQUENCE OF pneumonia, left lung and fatty metamorphosis of liver, marked									4-6 days
(c)									10-15 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
			19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
Schwartz W D H O III M.D.						12/18/68			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER						
E.W. DITTO, III, M.D.			215 W WASHINGTON			HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL			12/20/68		ROSE HILL CEMETERY		HAGERSTOWN, WASHINGTON, MD.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Charles M. Rausch			HAGERSTOWN, MARYLAND			DEC 20 1968		Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VA 15 (4)
30M REV. 1/68

18335		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				18348	
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH		2b. HOUR	
First Middle Last BLA Arance William Barnhart				Month Day Year December 13 1968		40 12 P. M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
MALE		White		April 10, 1896		72 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Lancaster Co., Pa.		U.S.A.				Washington County Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Williamsport		Sanitarium		Wood Worker		Furniture	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Washington Hagerstown				2423 Virginia Ave.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
First Middle Last Luther M Barnhart		First Middle Last Susan A Staumbaugh					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No		214-09-0666A		Delmont Barnhart (son)		2423 Virginia Ave Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Stroke							
DUE TO, OR AS A CONSEQUENCE OF							
(b) General arteriosclerosis							
DUE TO, OR AS A CONSEQUENCE OF							
(c) 334x							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
Metastatic Cancer of Right Lung							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
		HOUR A.M. Month Day Year P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No.			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE							
Francis Rosillo							
22d. PHYSICIAN'S NAME (Type)							
FRANCIS ROSILLO							
22e. ADDRESS							
580 Northern Ave. Hagerstown							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		12/15/68		Rest Haven Cemetery		Hagerstown-Washington-Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm. G. Horst		Rest Haven Funeral Chapel		Hagerstown, Md.		DEC 18 1968	
Charles Judge							

MEDICAL CERTIFICATION

2nd
 General
 Committee of the

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18336
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

18349

1. DECEASED-NAME (Type or print) First Middle Last Walter Mathias Beitler, Sr.			2a. DATE OF DEATH Month Day Year December 15 1968			2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 15, 1888		6. AGE (In years last birthday) 80 YRS.	
7a. BIRTHPLACE (State or foreign country) Halfway Wash. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Car Inspector		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 27 Potomac St.		14. FATHER'S NAME First Middle Last John Samuel Beitler		15. MOTHER'S MAIDEN NAME First Middle Last Ella Nora Kahoe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 705-10-4747		17. INFORMANT Address Mrs. Eva A. Beitler 27 Potomac St. Boonsboro, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> 486X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>493X</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>SEVERAL DAYS - ABOUT 3-4</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>UREMIA</u> <u>ARTERIOSCLEROTIC HEART DISEASE SEVERE & CONGESTIVE FAILURE AND</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 11, 1968</u> , to <u>Dec 15, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Dec 15</u> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Quamruba</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>12/17/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>RIZALITO AMARILLO</u>				22e. ADDRESS <u>120 W. MAIN ST SHARPSBURG MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/18/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u>		ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 20 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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DEC 10 1988

W. C. Hunt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18339

18350

1. DECEASED-NAME (Type or print) NELLIE M. BITNER			2a. DATE OF DEATH Dec. Month 19 Day 1968			2b. HOUR 12:45 PM					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 2/22/1905		6. AGE (In years lost birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md					
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. Co. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MD.			13b. COUNTY WASH.		13c. CITY OR TOWN Hagerstown		13d. HYPO CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1630 PARK Rd.		
14. FATHER'S NAME First Samuel Middle Raley Last BITNER			15. MOTHER'S MAIDEN NAME First UNKNOWN Middle UNKNOWN Last UNKNOWN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 1-34-77		17. INFORMANT Glen R. Bitner - Hagerstown, Md. Address Hagerstown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis 5321 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1 day. (b) ruptured duodenal ulcer. DUE TO, OR AS A CONSEQUENCE OF 1-2 days. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic lymphocytic leukemia.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. F. YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Oct 57 , to Ante , 19 68 , that (I) (we) lost saw the deceased alive on 19 Dec 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard T. Binford		22c. DATE SIGNED 12/20/68		22d. PHYSICIAN'S NAME (Type) Richard T. Binford M.D.		22e. ADDRESS 1135 Potomac Ave. - Hagerstown, Md.					
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE 12/22/68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION (City or Town) Greencastle, PA.		(County) PA.		(State)	
24. FUNERAL DIRECTOR A.E. Minnich - Greencastle, PA.		25a. REC'D BY REGISTRAR DEC 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge							

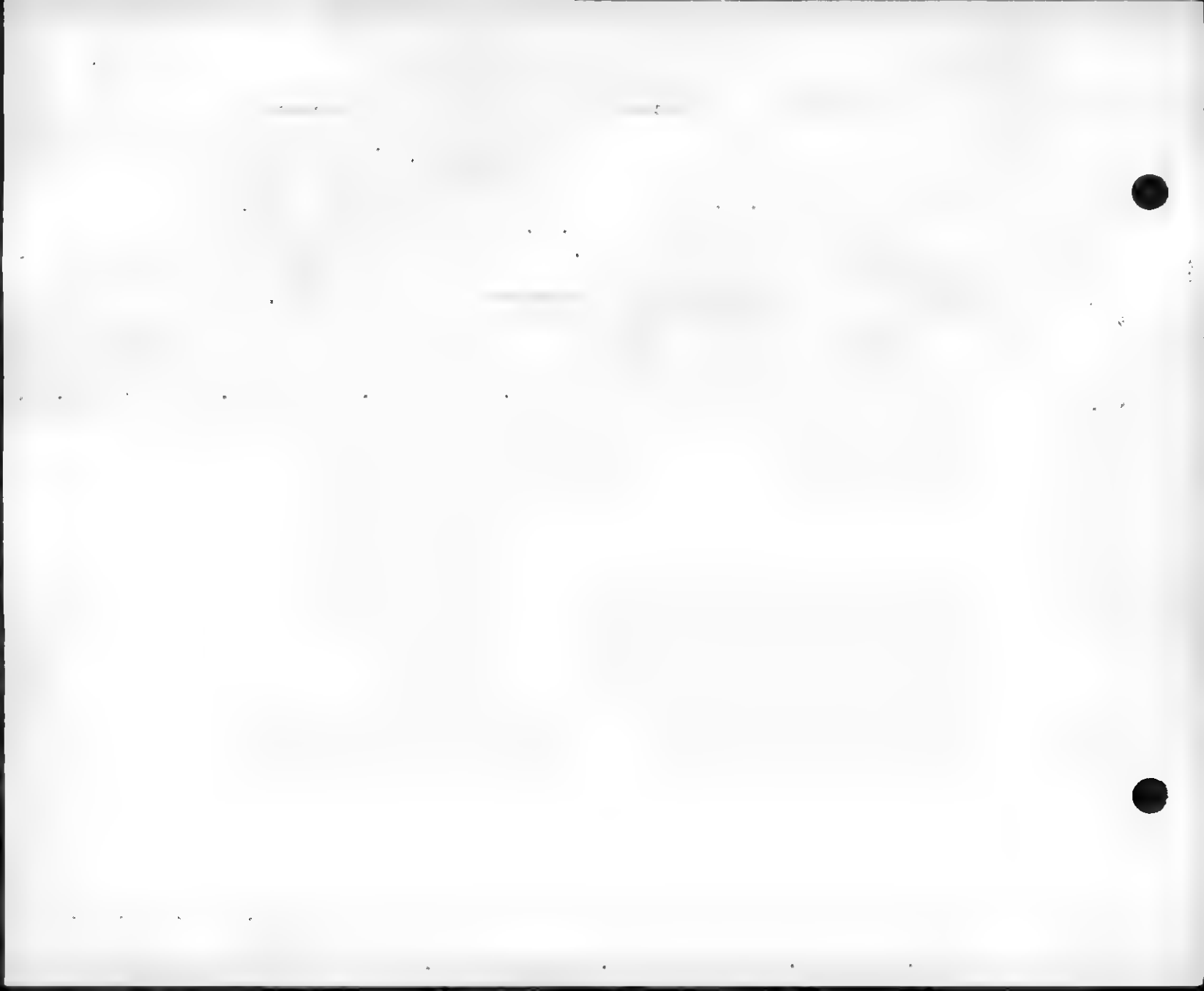
MEDICAL CERTIFICATION



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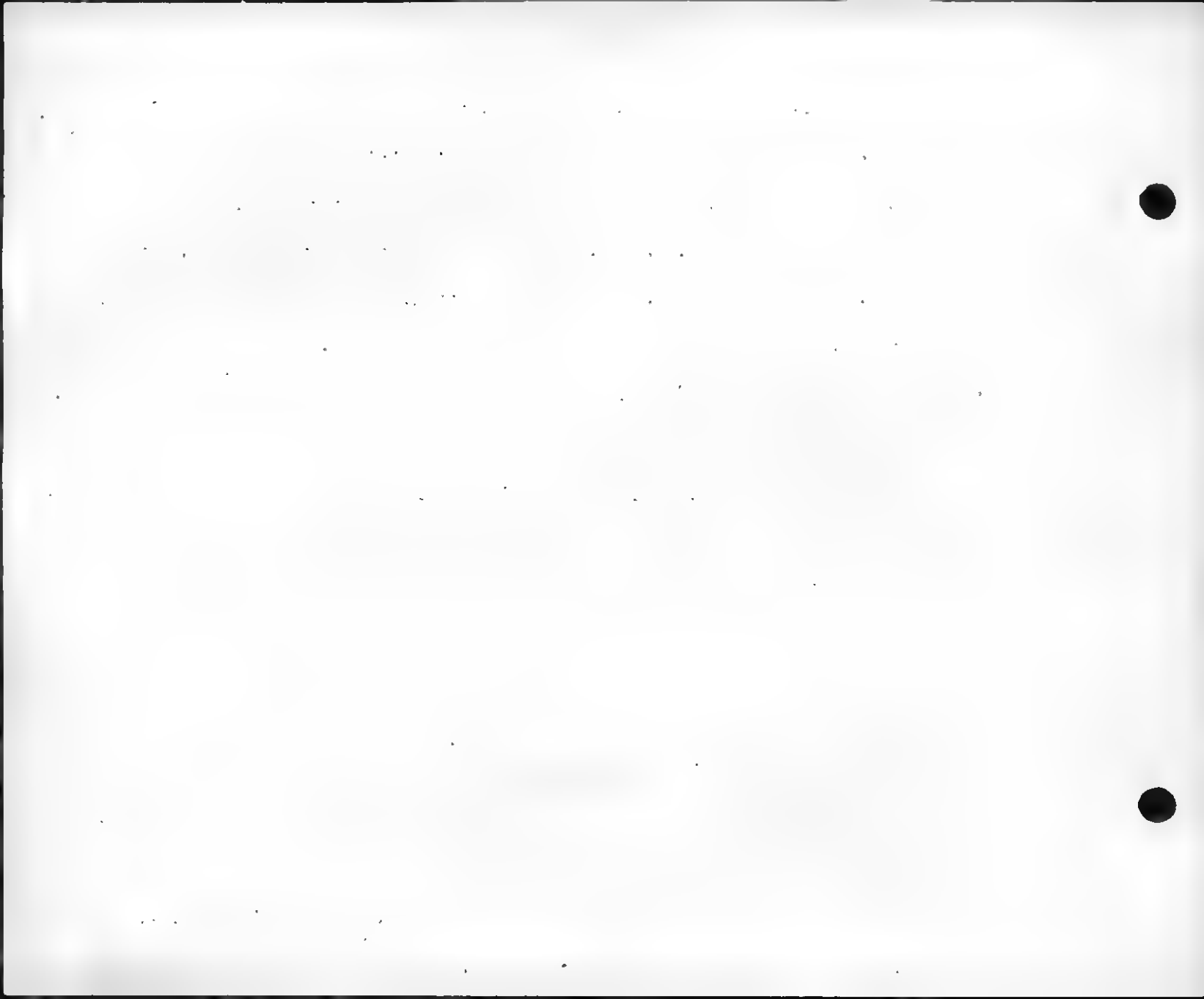
18333										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										18351									
1. DECEASED-NAME (Type or print) First Middle Last Milton Reichard Bloom										2a. DATE OF DEATH Month Day Year December 10, 1968										2b. HOUR 9:45 A.M.									
3. SEX Male					4. RACE White					5. DATE OF BIRTH August 21, 1909					6. AGE (In years last birthday) 59 YRS.					7. UNDER 1 YEAR MONTHS DAYS HOURS MIN 3 19					8. UNDER 24 HRS. HOURS MIN 19				
7a. BIRTHPLACE (State or foreign country) Bakersville, Md.					7b. CITIZEN OF WHAT COUNTRY? U. S. A.					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Washington Md														
10. CITY OR TOWN OF DEATH Hagerstown					11. NAME OF HOSPITAL OR INSTITUTION (Give street address) Washington Co. Hospital					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Operator					12b. KIND OF BUSINESS OR INDUSTRY City Water Dept.														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland					13b. CITY OR TOWN Washington					13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13d. STREET AND NUMBER Rfd. 2														
14. FATHER'S NAME First Middle Last Richard D. Bloom					15. MOTHER'S MAIDEN NAME First Middle Last Nannie Mongan																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.					16b. SOCIAL SECURITY NO. 214-09-6430					17. INFORMANT Address Mrs. Florence V. Bloom, Rfd. 2, Boonsbore, Md																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Art. sclerotic Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs Minutes																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 6/24 , 19 67 , to Dec 10 , 19 68 , that (I) (was) last saw the deceased alive on Dec 10 , 19 68 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) not view the body after death.																													
22b. SIGNATURE Adney Novenstein M.D.										22c. DATE SIGNED 10-11-68					22d. PHYSICIAN'S NAME (Type) ADNEY NOVENSTEIN					22e. ADDRESS FUNKSTOWN MD									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 12-13-68					23c. NAME OF CEMETERY OR CREMATORY Boonsbore Cemetery					23d. LOCATION (City or Town) (County) (State) Boonsbore, Wash. Co., Md.														
24. FUNERAL DIRECTOR John M. Bast, Jr. 112 N. Main St. Boonsbore, Md										25a. REC'D BY REGISTRAR DEC 16 1968					25b. REGISTRAR'S SIGNATURE Charles Judge														



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<div style="display: flex; justify-content: space-between;"> 18320 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 18352 </div>											
1. DECEASED NAME (Type or print) Charles Edward Boward						2a. DATE OF DEATH 12 Month 21 Day 68 Year			2b. HOUR 8:20 P. M.		
3 SEX male		4. RACE white		5. DATE OF BIRTH June 9, 1902			6 AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.					
10. CITY OR TOWN OF DEATH Hagerstown			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sales Represent.			12b. KIND OF BUSINESS OR INDUSTRY Trucking		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 844 Guilford Ave.		
14. FATHER'S NAME First Middle Last George R. Boward						15. MOTHER'S MAIDEN NAME First Middle Last Minnie C. Lechrone					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? no Yes, no, or unknown (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 214-09-0533		17. INFORMANT Address Mary Jane Boward Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>705X</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Nephrosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>Years</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>746X Diabetes Mellitus</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1 Dec</u> , 19 <u>68</u> , to <u>22 Dec</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>22 Dec</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>12/23/68</u>			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE 12-24-68		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.					
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home Hagerstown, Md.						25a. REC'D BY REGISTRAR DEC 27 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



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MEDICAL CERTIFICATION

183530										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										18353																																																											
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR																																																	
LUTHER										PETER										BOWMAN										DECEMBER										Month 10 Day 68 Year										6 a M																													
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										F UNDER 1 YEAR										IF UNDER 24 HRS.																													
MALE										WHITE										JULY 4, 1894										74 YRS.										MONTHS										DAYS										HOURS										M.N.									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																																							
MARYLAND										U.S.A.																				WASHINGTON																																																	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
HAGERSTOWN										WASHINGTON COUNTY HOSP.										RETIRED LABOR										RUBBER FACTORY																																																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET AND NUMBER																																							
MARYLAND										WASHINGTON										HAGERSTOWN										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										241 1/2 E. FRANKLIN ST.																																							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										First Middle Last										First Middle Last																																																	
SCOTT										BOWMAN										AMANDA										MULLENIX																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										241 1/2 Address: E. FRANKLIN ST.																																																	
NO										220-09-9310										MRS. BLANCHE BOWMAN										HAGERSTOWN, MARYLAND																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)										PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																											
491X										IMMEDIATE CAUSE (a) Pneumonia, bilateral										2 wks.																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Chronic bronchitis and emphysema										years																																																											
										(c)																																																																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										241X																																																																					
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
																				YES <input type="checkbox"/> NO <input type="checkbox"/>																																																											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																																											
										HOUR A.M. Month Day Year P.M. 19																																																																					
21d. INJURY OCCURRED										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION										Street or R.F.D. No. City or Town County State																																																	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>																																																																															
22a. I certify that (I) (this hospital) attended the deceased from Nov 1963, to 12-10, 1968, that (I) (we) last saw the deceased alive on 12-9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																																															
22b. SIGNATURE										22c. DATE SIGNED																																																																					
Charles C. Spencer, M.D.										12/10/68																																																																					
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																																					
CHARLES C. SPENCER, M.D.										145 S PROSPECT ST., HAGERSTOWN, MD.																																																																					
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																																																	
BURIAL										12/12/68										REST HAVEN CEMETERY										HAGERSTOWN, WASHINGTON, MD.																																																	
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																	
Charles M. Rouger										HAGERSTOWN, MARYLAND										DEC 13 1968										Charles Judge																																																	



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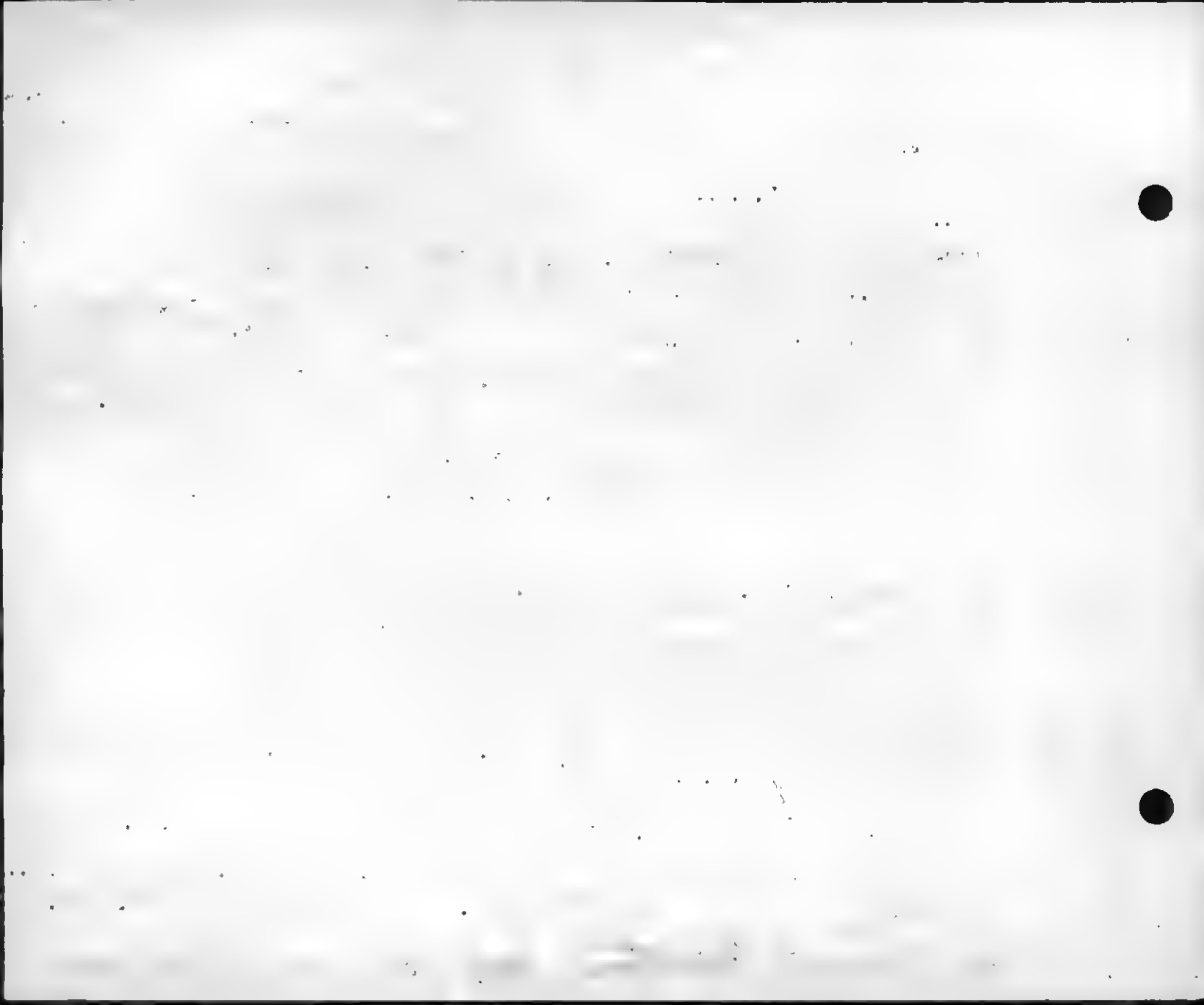
18331

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18354

1. DECEASED-NAME (Type or print) First Annie Middle Lydia Last Brägunier			2a. DATE OF DEATH Month Dec. Day 7 Year 1968		2b. HOUR 8.30 MIN. M
3. SEX Female	4. RACE White	5. DATE OF BIRTH September 23, 1881		6. AGE (In years last birthday) 87 YRS.	7. UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A..	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON Md.	
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Practical nurse.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD..		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 538 West Wilson Boulevard,
14. FATHER'S NAME First DANIEL Middle RICE Last 			15. MOTHER'S MAIDEN NAME First MARY Middle ELIZABETH Last POTTS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. None		17. INFORMANT MRS. LOUISE EASTERDAY HAGERSTOWN Address MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4129 IMMEDIATE CAUSE (a) Complete heart block DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 20 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4129 Fracture of rt. intertrochanteric.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Dec. 7, 1967 to Dec. 7, 1968 , that (I) (we) last saw the deceased alive on Dec. 7, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Chong Choon Han				22c. DATE SIGNED Dec. 7, 1968	
22d. PHYSICIAN'S NAME (Type) Chong Choon Han				22e. ADDRESS Western Md. State hosp., Hagerstown, Md..	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE 12/9/68	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City or town) (County) HAGERSTOWN WASH. MD.
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.				25a. REC'D BY REGISTRAR DEC 10 1968	25b. REGISTRAR'S SIGNATURE Charles Judge



MARTIN COUNTY DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

18355

I-40, File # 91-22 1/28/69 W.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE West Virginia COUNTY Berkeley c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gerrardstown d. STREET ADDRESS Route 1	
3. NAME OF DECEASED (Type or print) Mamie Catherine Braithwaite		4. DATE OF DEATH Month December Day 30 Year 19 68	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH October 2, 1896 9. AGE (In years last birthday) 71 7/8 rs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House duties 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (County & State, or foreign country) Berkeley County, W. Va. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William T. Hess		14. MOTHER'S MAIDEN NAME Mary C. McDaniel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Anthony W. Braithwaite		Address Route 1 Gerrardstown, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia DUE TO (b) Generalized metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Cancer of left lung			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 163x 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour none a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that (I) (this hospital) attended the deceased from Oct. 19, 68 to Dec. 30, 1968 , that (I) (we) last saw the deceased alive on Dec. 30, 1968 , and that death occurred at P.M. , from the causes and on the date stated above.			
22a. SIGNATURE <i>Harold R. Brown, Jr.</i>		22b. DATE SIGNED Jan 21 69	
22c. PHYSICIAN'S NAME (Type) Harold R. Brown, Jr. D		22d. ADDRESS 302 Potomac St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 2, 1969	
23c. NAME OF CEMETERY OR CREMATORY Pleasant View Memory Gardens		23d. LOCATION (City, town or county) (State) Martinsburg, W. Va.	
24 FUNERAL DIRECTOR'S SIGNATURE <i>Harold R. Brown</i>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE JAN 6 1969 <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. By the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last Charles Andrew Brown						2a. DATE OF DEATH Month Day Year December 11 1968			2b. HOUR M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 3, 1886 1887			6. AGE (In years last birthday) 82 1/2 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Carlisle, Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.					
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Optometrist			12b. KIND OF BUSINESS OR INDUSTRY Optometry		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 802 Forrest Drive		
14. FATHER'S NAME First Middle Last Andrew nm Brown				15. MOTHER'S MAIDEN NAME First Middle Last Anna Margaret Warner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO. 212-38-9793		17. INFORMANT Address Mrs. Rose E. Brown 802 Forrest Dr., Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal carcinomatosis 1971 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1992											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (the physician) attended the deceased from 12/10/ , 19 68 , to 12/11 , 19 68 , that (I) (we) last saw the deceased alive on 12/11 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Howard N. Weeks						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12/13/68			
22d. PHYSICIAN'S NAME (Type) Howard N. Weeks, M. D.						22e. ADDRESS 580 Northern Ave., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/15/68		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown-Washington-Md.					
24. FUNERAL DIRECTOR Rest Haven Funeral Chapel		ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DEC 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

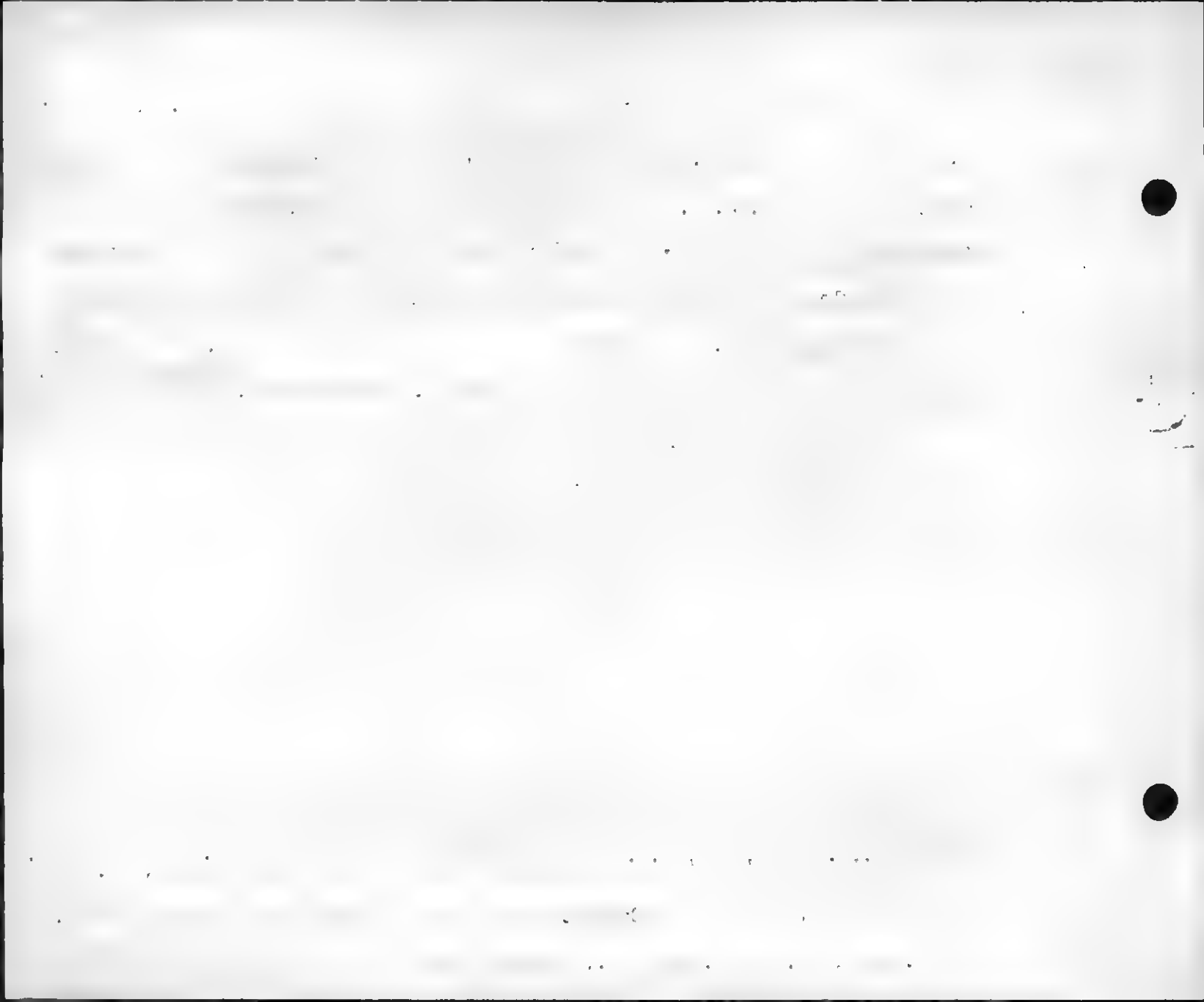


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										18357			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or Print)			First		Middle		Last			2a DATE KNOWN OF DEATH Month Day Year		2b HOURS 2:30	
Mary			Edna		Brown						Dec. 19, 1968		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year	
Female		White		June 9, 1915		53 YRS		6 10				December 19, 1968	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			2d HOUR 2:30	
Maryland			U. S. A.						Washington			Md	
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY	
Hagerstown				65 1/2 West Franklin Street				Housewife				Own Home	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Maryland				Washington		Hagerstown				65 1/2 West Franklin Street			
14. FATHER'S NAME					15 MOTHER'S MAIDEN NAME					ADDRESS			
First Middle Last					First Middle Last					Hagerstown, Md.			
George W. Domer					Ada N. Kendall					Charles E. Garlock 65 1/2 W. Franklin Street,			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT				ADDRESS			
No						Charles E. Garlock				65 1/2 W. Franklin Street,			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion & perforation													
DUE TO, OR AS A CONSEQUENCE OF (b) heart & hemopericardium										4 m m s			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
Nephrosclerosis													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month Day Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH				19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED					
E. W. Ditto, III, M.D.								12-20-68					
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER				217 W. Washington St.					
								Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial		12/23/68		Boonsboro Cemetery				Boonsboro, Washington, Md.					
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John H. Bast, Jr.						112 N. Main St., Boonsboro, Md.		DEC 23 1968		Charles Judge			



FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR	
Mervin Clarence Brown						Month Day Year			12 17 1968 3:45 PM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR	8 UNDER 24 HRS	2c DATE PRONOUNCED DEAD			2d HOUR	
male	white	1-26-1898	70 YRS	MONTHS DAYS	HOURS MIN	Month Day Year			12 17 1968 4:45 PM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			12b KIND OF BUSINESS OR INDUSTRY	
West Virginia		USA				Washington			Aircraft Mfg	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Wash. County Hospital			Assembly			Aircraft Mfg	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?	
Md.			Wash.			Hagerstown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER			14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?	
829 Chestnut, St.			First Middle Last			First Middle Last			yes no (If yes give year or dates of service)	
			William L. Brown			Mary E. LeMaster			yes no WW I	
16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
234-24-4125			Mrs. Ruth Brown Hagerstown, Md.						PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Portal Aneurysm - Marked Aneurysm	
									5718	
									DUE TO, OR AS A CONSEQUENCE OF (b) + Hepatic failure with	
									DUE TO, OR AS A CONSEQUENCE OF (c) Bilateral Lobular Pneumonia	
									48 hr	
									22 hr	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
5810										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			P.M. 19							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State				
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)	
Burial			12-21-68			Elmwood Cemetery			Shepherdstown, W. Virginia	
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REG STRAR			25b REGISTRAR'S SIGNATURE	
Minnich Funeral Home Hagerstown, Md.						DEC 23 1968			[Signature]	

100-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
304 REV. 1-68

18346										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										18359																																																	
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																	
EDWARD STUART BUSHONG SR.										DECEMBER Month 22 Day 68 Year										6:18am																																																	
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR										IF UNDER 24 HRS.																			
MALE										WHITE										JUNE 10, 1904										64 YRS.										MONTHS										HOURS										MIN.									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																																							
WEST VIRGINIA										U.S.A.																				WASHINGTON										Md																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																																							
HAGERSTOWN										WASHINGTON COUNTY HOSP.										LAWYER										LAW																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before adm ssion) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																													
MARYLAND										WASHINGTON										BOONSBORO										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										R.F.D. #1																													
14. FATHER'S NAME First Middle Lost										15. MOTHER'S MAIDEN NAME First Middle Lost																																																											
DANIEL B BUSHONG										SALLY ROBINSON																																																											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																																							
NO										220-34-0182										MRS. RACHAEL BUSHONG										BOONSBORO, RFD #1																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART 1. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
5-719										IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i>										7 days																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) <i>Arteriosclerosis</i>										1.4%																																																	
										(c)																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).										<i>Arteriosclerotic Heart Disease - Atrial fibrillation</i>																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)										21f. LOCATION Street or R.F.D. No City or Town County State																																																	
22a. I certify that (I) (the hospital) attended the deceased from April 1964, to Dec 24, 1968, that (I) (we) last saw the deceased alive on Dec 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																																					
22b. SIGNATURE										DEGREE										ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c. DATE SIGNED																																							
22d. PHYSICIAN'S NAME (Type)										EDSON B MOODY, M.D.										22e. ADDRESS										363 CLEVELAND AVE., HAAGERSTOWN, MD.																																							
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																																							
BURIAL										12/24/68										ST MARK'S CEMETERY										BOONSBORO, WASHINGTON, RD#1, MD.																																							
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																							
Charles M. Rieger										HAAGERSTOWN, MARYLAND										DEC 30 1968										Charles Judge																																							

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

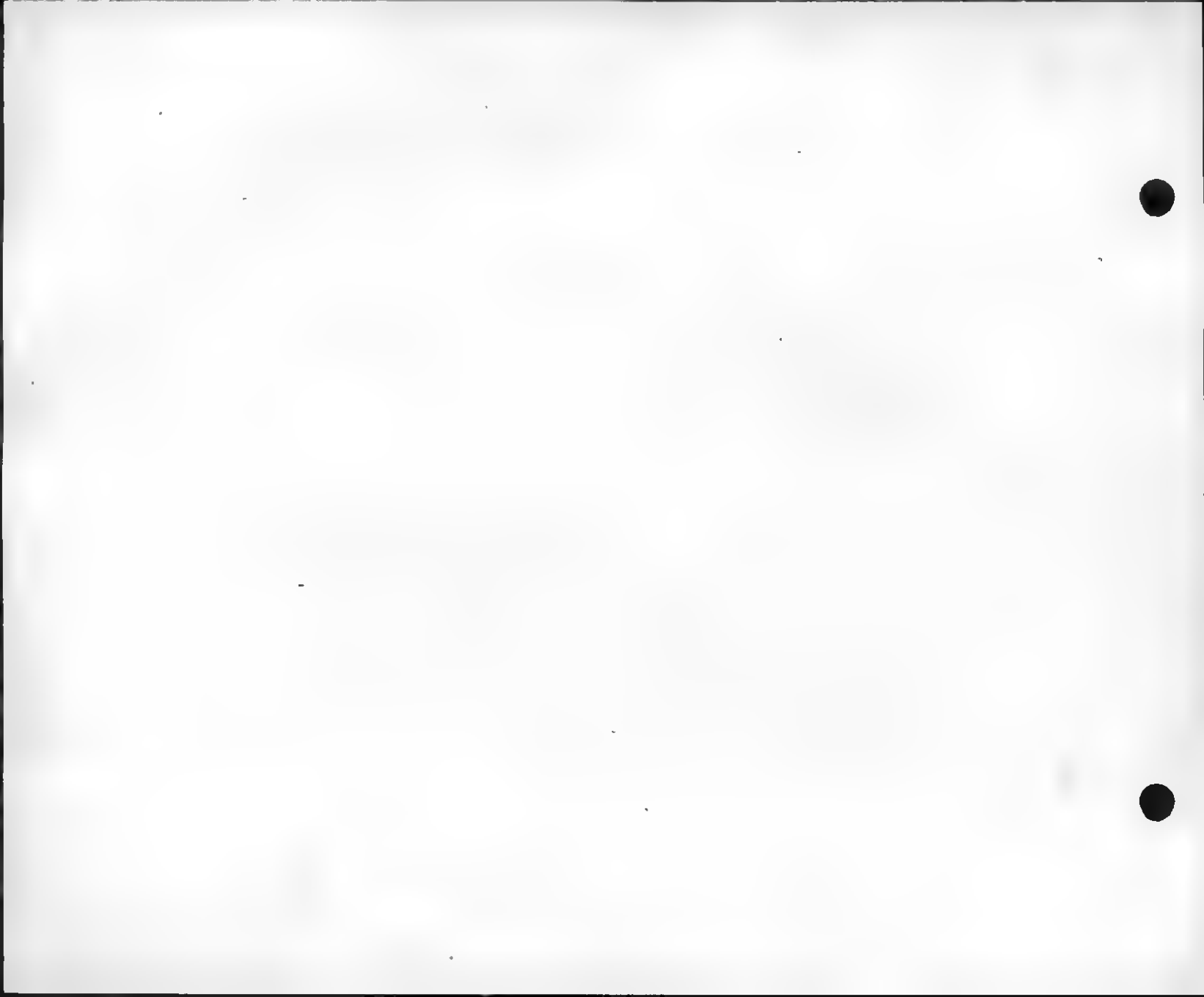
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 13 Film 407
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
12/23/68 kk 18360
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18360

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		Month		Day		Year		2b HOUR		
OTIS		MC KINLEY		CAGLE				MATED		12		89		08		a M		
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)	F UNDER YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month		Day		Year		2d HOUR	
Male	White	7-30-22		46 YRS	MONTHS		DAYS		12		9		1968		8:30 a M			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH												
North Carolina		USA				Washington County		Md.										
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY						
Hagerstown				Bethel Street														
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission)				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER								
Maryland				Washington		Hagerstown		YES <input type="checkbox"/> NO <input type="checkbox"/>		201 N. Jonathan St.								
14 FATHER'S NAME						15 MOTHER'S MAIDEN NAME												
First Middle Last						First Middle Last												
Zoro M. Cagle						Mattie Corchran												
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS												
yes				WII		William Cagle Hendersonville, N. C.												
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Exposure																		
DUE TO, OR AS A CONSEQUENCE OF (b)																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
Chronic alcoholism, contusion forehead and laceration of scalp.																		
19a DATE OF OPERATION						19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?						
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.						21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
						19												
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>						21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f LOCATION Street or R.F.D. No City or Town County State						
Rear of Bethel St.						Behind Ebenezer Church, Hagers.						Washington Md.						
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																		
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER						22b DATE SIGNED						
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER						12/10/68						
Howard N. Weeks, MD. Washington						DEPUTY MEDICAL EXAMINER												
ADDRESS (Street, city, town or county)																		
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)						
removal				12 10 68				Tryon Cemetery				Tryon North Carolina						
24 FUNERAL DIRECTOR ADDRESS												25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
Minnich Funeral Home Hagerstown, Md.												DEC 16 1968		Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18361																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First Walter			Middle Rodney			Last Carey			2a. DATE OF DEATH 12 Month 21 Day 68 Year			2b. HOUR M		
3 SEX male			4. RACE white			5. DATE OF BIRTH 2-28-1901			6. AGE (In years last birthday) 67 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Penna.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington Md.								
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Wash.			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER RFD # 2					
14. FATHER'S NAME First Middle Last John Samuel Carey			15. MOTHER'S MAIDEN NAME First Middle Last Sarah E. Gearhart														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes			16b. SOCIAL SECURITY NO. (If yes give year or dates of service) WW II 197-09-9582			17. INFORMANT Address Myrtle Cooper Hagerstown, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis (advanced)</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF (a) _____ (b) _____ (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>002.1 Severe Anemia</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>not known</u>					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 21</u> , 1968, to <u>Dec 21</u> , 1968, that (I) (we) last saw the deceased alive on <u>Dec 21</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>B.B. Kneisley M.D.</u>			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>Dec. 24, 1968</u>								
22d. PHYSICIAN'S NAME (Type) B.B. KNEISLEY			22e. ADDRESS <u>1406 Washington St Hagerstown, Md.</u>														
23a. BURIAL, CREMATION, or other disposal (Specify) Burial			23b. DATE 12-24-68			23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.								
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home Hagerstown, Md.			25a. REC'D BY REGISTRAR DEC 27 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

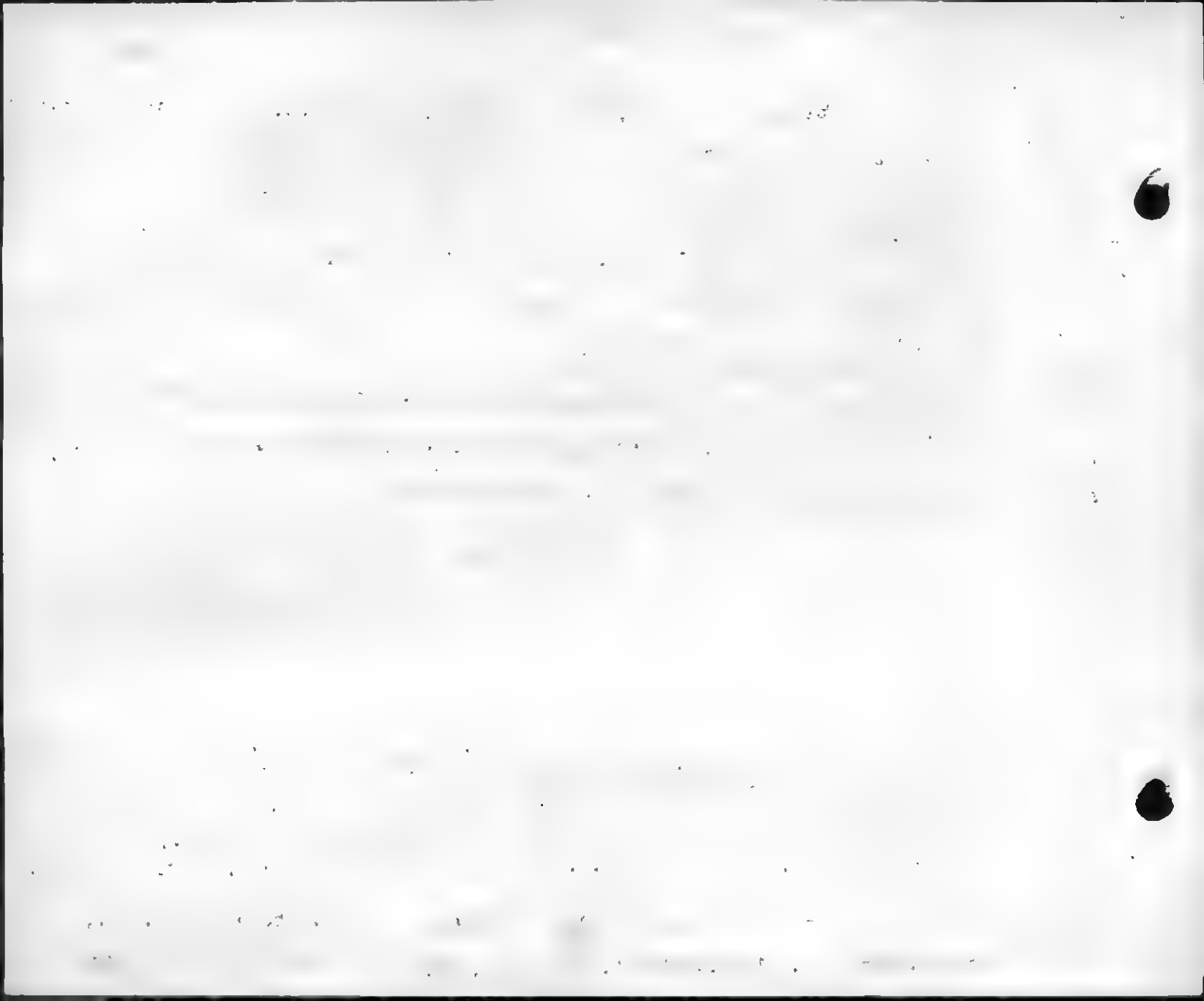


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR	
Kathryn Percilla Conkling						Dec. 29 1968		3:50 M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		? 1875		93 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
New York		USA				WASHINGTON			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
HAGERSTOWN		WESTERN MD. STATE HOSPITAL		Housewife					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Washington		Boonsboro				Route 2	
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
George Washburn			Kathryn						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
No		None		Western Md. State Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic heart disease</u>									13 yrs
4120 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)									
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)									
21f. LOCATION Street or RFD No City or Town County State									
22a. I certify that (I) person attended the deceased from <u>Feb. 14, 1963</u> , to <u>Dec. 29, 1968</u> , that (I) was last saw the deceased alive on <u>Dec. 29, 1968</u> , and that in (my) best opinion death occurred on the date and hour and from the causes stated above, (I) we (did) not view the body after death.									
22b. SIGNATURE <u>Fe U. Porciuncula M.D.</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>									
22c. DATE SIGNED <u>12/30/68</u>									
22d. PHYSICIAN'S NAME (Type) <u>Fe U. Porciuncula, M.D.</u>									
22e. ADDRESS <u>Western Maryland State Hospital 1500 Pennsylvania Ave., Hagerstown, Md.</u>									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1- 1- 69		Boonsboro Cemetery		Boonsboro, Wash. Co., Md.			
24. FUNERAL DIRECTOR ADDRESS									
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.									
25a. REC'D BY REGISTRAR <u>Jan 6 1969</u>									
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

VA 47-14
30M SEP 1 1968

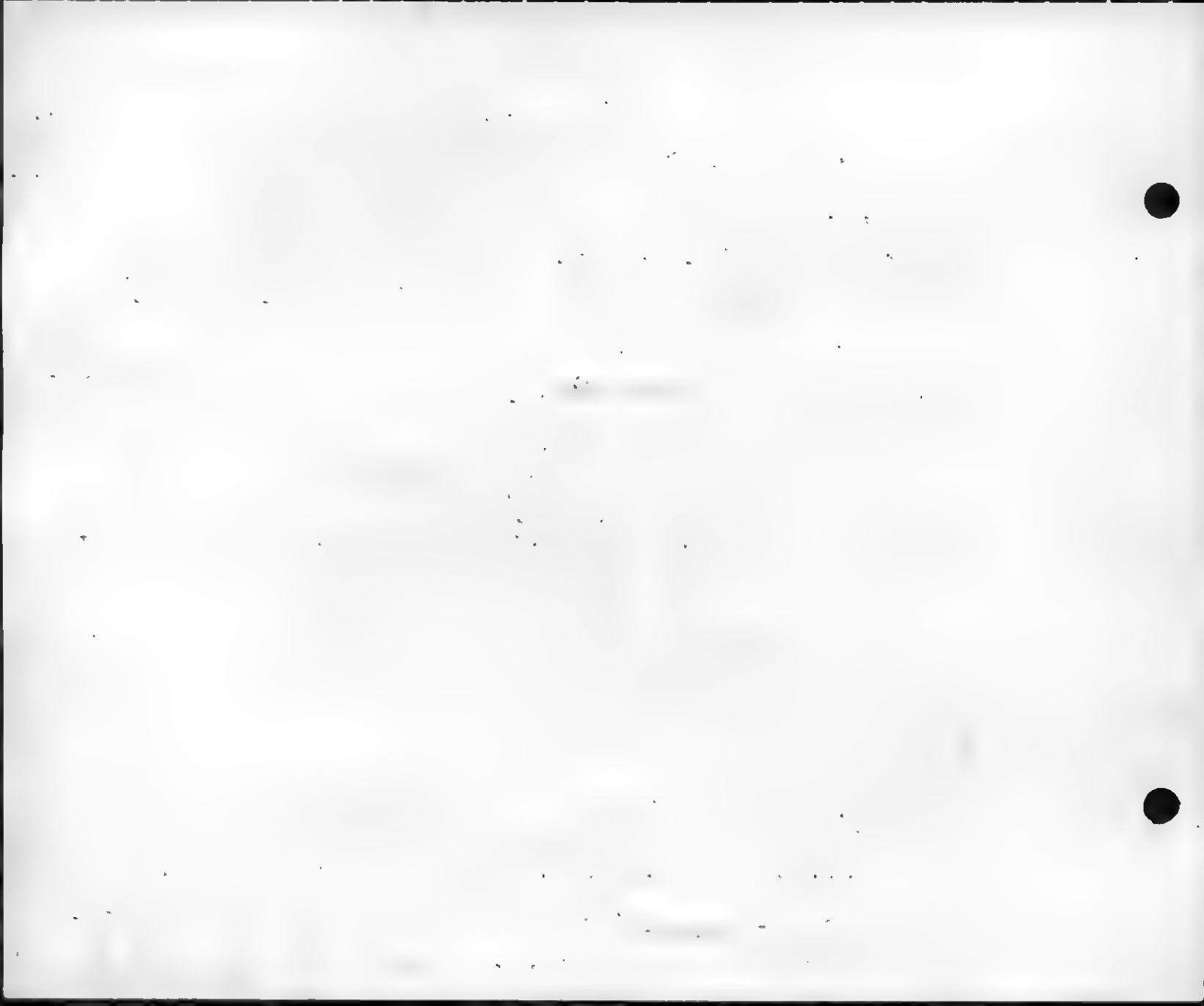


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-10. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18350										18363																									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										MEDICAL EXAMINER'S CERTIFICATE OF DEATH																									
1 DECEASED NAME (Type or Print)			First			Middle			Last			2a DATE KNOWN OF ESTI- DEATH MATED			Month			Day			Year			2b HOUR											
Charles			Sylvester			Coyle						12-27-			1968						P. M.														
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 MRS		2c DATE PRONOUNCED DEAD			Month			Day			Year			2d HOUR											
Male		White		May 16, 1920		48 YRS		MONTHS		DAYS		12-			27-			68						5:40											
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				9 COUNTY OF DEATH																							
Keedysville, Md.				USA				WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				Washington												Md											
10. CITY OR TOWN OF DEATH						11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)						12b KIND OF BUSINESS OR INDUSTRY																	
Hagerstown						57 S. Potomac St. (Colonial Hotel)						Inspector						Aircraft																	
13a USUAL RESIDENCE (Where deceased lived at least 1 year)						13b COUNTY						13c CITY OR TOWN						13d INSIDE CITY LIMITS?						13e STREET AND NUMBER											
Maryland						Washington						Hagerstown						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						57 S. Potomac St.											
14 FATHER'S NAME						15. MOTHER'S MAIDEN NAME																													
Sylvester						Florence						Anna						Rohrer																	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b SOCIAL SECURITY NO.						17. INFORMANT						ADDRESS																	
No						214-16-0865						Mrs. Carroll Uhler						1201 Ravenwood Heights, Hagerstown, Md.																	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aspiration of vomitus																		Few minutes																	
571.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																																			
DUE TO, OR AS A CONSEQUENCE OF Multiple hematomas and bruises																																			
(b) (old and recent) left eye, left shoulder, left																																			
DUE TO, OR AS A CONSEQUENCE OF forearm & elbow, left & right back, right hip & right																																			
(c) leg. Fatty metamorphosis of liver, marked.																		Recent																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																			
581.0																																			
19a DATE OF OPERATION																		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?											
																								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>						21b TIME OF INJURY Month, Day, Year						21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																							
CAUSE OF DEATH						HOUR A.M.																													
						P.M.						19																							
21d INJURY OCCURRED						21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f LOCATION Street or R.F.D. No						City or Town						County						State					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>																																			
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>																																			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>																																			
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER						22b DATE SIGNED																							
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER						DEPUTY MEDICAL EXAMINER						12-28-68																	
DR. E. W. DITTO, JR.						215 W. Washington St., Hagerstown, Md.																													
23a BURIAL, CREMATION, REMOVAL (Specify)						23b DATE						23c NAME OF CEMETERY OR CREMATORY						23d LOCATION (City or Town)						(County)						(State)					
Burial						12/30/68						Mountain View Cemetery						Sharpsburg-Washington-Md.																	
24 FUNERAL DIRECTOR						ADDRESS						25a REC'D BY REGISTRAR						25b REGISTRAR'S SIGNATURE																	
Rest Haven Funeral Chapel						Hagerstown, Md.						DEC 31 1968						Charles Judge																	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI-DEATH MATED		2b. HOUR	
BLANCHE EDNA CRAWFORD						Dec 18 1968		3:45 PM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	July 20, 1893	75 YRS			Dec. 18		4:00 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		U.S.A.				Washington			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagers town			545 Maryland Ave			Housewife		Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital give street address)			13b. CITY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Maryland			Washington		Hagers town		545 Maryland Ave		
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last				
James J. Miller					Laura V. Crilley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS				
no			217-32-7303		John E. Crawford, 16 Avalon Ave Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Coronary atherosclerosis and DUE TO, OR AS A CONSEQUENCE OF (c) Advanced gen/ arteriosclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Recent viral gastro-enteritis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Twice
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)				
CAUSE OF DEATH									
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			12-19-68			
Edward W. Ditto, III, M.D.			DEPUTY MEDICAL EXAMINER			217 W. Washington St. Hagerstown, Maryland			
			ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12/21/68		Rest Haven Cemetery		Hagerstown, Md.			
24. FUNERAL DIRECTOR			25a. REC'D BY REG. STR.			25b. REG. STR.'S SIGNATURE			
Andrew K. Coffman Funeral Home, Inc			Hagers town, Md.			DEC 26 1968			
						Charles Judge			



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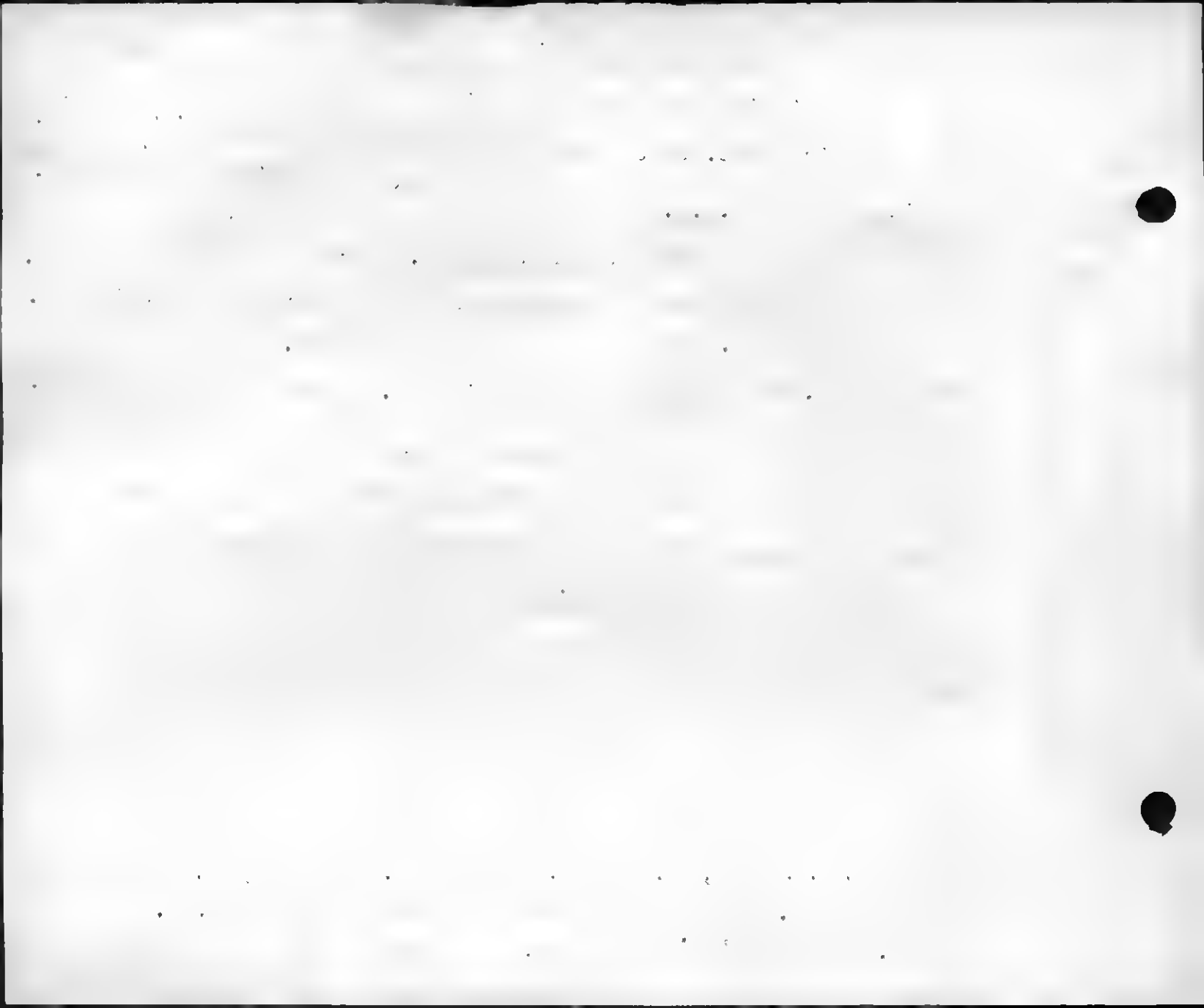
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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18352										18365																			
MAY 1968										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																													
1. DECEASED NAME (Type or Print)					First Middle Last					20. DATE KNOWN OF ESTI- DEATH MATED					2b HOUR														
Albert Nihiser Davis										Dec. 1, 68 19					10 p. M.														
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD					2d. HOUR												
Male		White		Sept. 13/13		35 YRS		MONTHS DAYS		HOURS MIN.		December 2, 1968					12:50 p. M.												
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
Washington					U.S.A.										Washington					Md.									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Hagerstown					26 1/2 East Franklin St. Labor										Water Dept														
13a. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET AND NUMBER									
Maryland					Washington					Hagerstown					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					26 1/2 East Franklin St.									
14. FATHER'S NAME					First Middle Last					15. MOTHER'S MAIDEN NAME					First Middle Last														
Charles W. Davis										Carrie M. Norris																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS														
Yes					N.W.#2					214-09-5298					Mrs Viola M. Burger					Havre De Grace Md. Box 206									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Thrombosis of both middle cerebral arteries										Recent																			
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										Several years																			
(b) Calcific aortic stenosis, severe																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c) Possible active endocarditis of aortic valve with																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
332X embolization.																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?																			
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>					21b. TIME OF INJURY Month, Day, Year					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
CAUSE OF DEATH					HOUR A.M. P.M. 19																								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No.					City or Town														
															County														
															State														
22a. I certify that I took charge of the remains described above, held on death resulted from:										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					22b. DATE SIGNED																			
EXAMINER'S NAME (Type)					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					12-1-68																			
Dr. E.W. Ditto, Jr.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																								
23a. BURIAL CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					Dec. 4, 1968					Rose Hill Cemetery					Hagerstown, Md.														
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Hagerstown, Md.										Andrew K. Coffman Funeral Home Inc.										DEC 6 1968					Charles J. J...				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

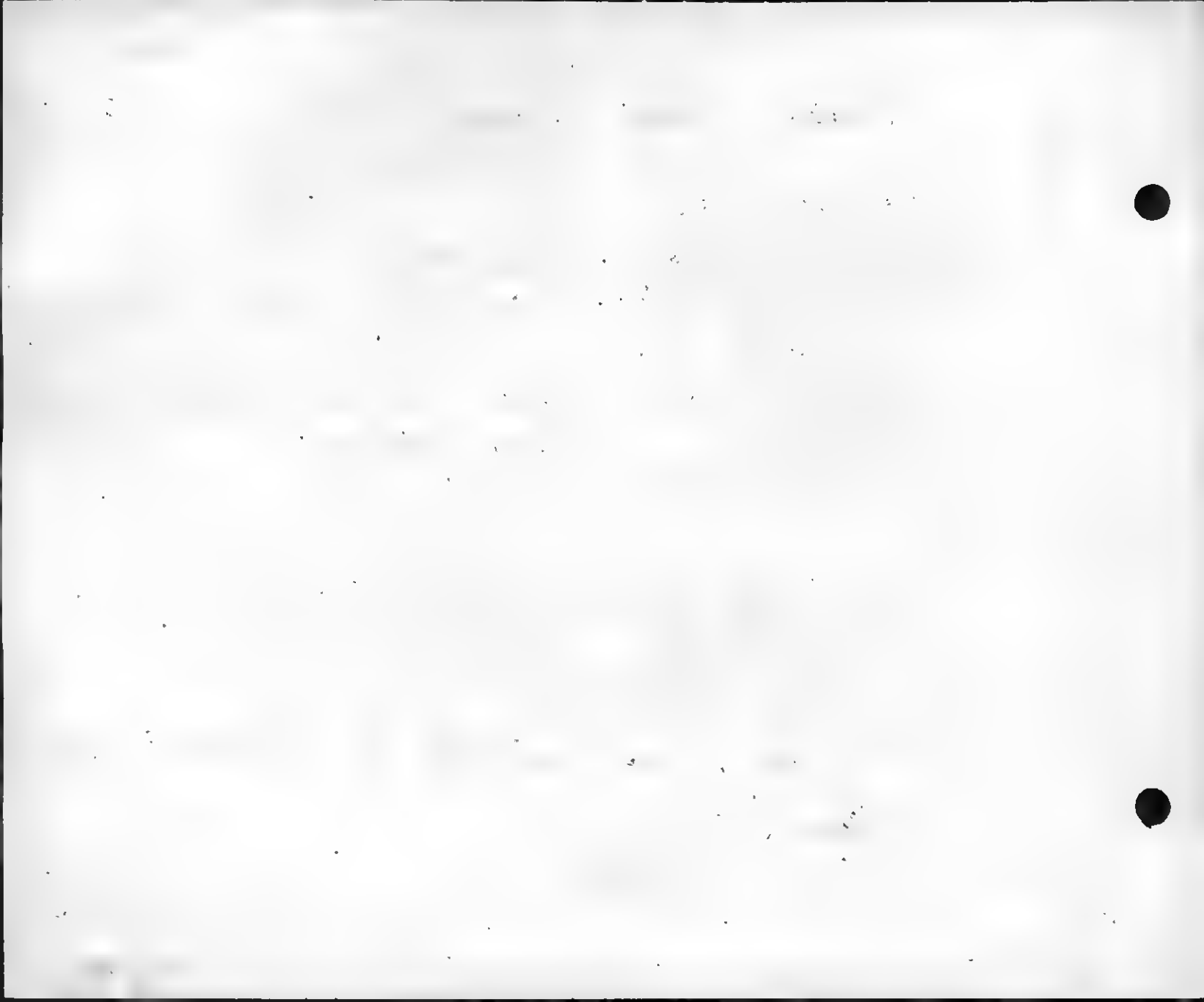
VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

18353

18366

1. DECEASED NAME (Type or print) <i>Margaret Viola Daener</i>			2a. DATE OF DEATH Month <i>Dec</i> Day <i>22</i> Year <i>1968</i>		2b. HOUR <i>5:55PM</i>
3 SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>4-12-1894</i>		6. AGE (In years last birthday) <i>74</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>WASHINGTON</i> Md.	
10. CITY OR TOWN OF DEATH <i>HAGERSTOWN</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>WESTERN MD. STATE HOSPITAL</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>None</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>	13c. CITY OR TOWN <i>Boonsboro</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>Route 1, Boonsboro Md.</i>
14. FATHER'S NAME First <i>Samuel</i> Middle <i>HIMES</i> Last <i>HIMES</i>		15. MOTHER'S MAIDEN NAME First <i>ANNIE</i> Middle <i>PIERCE</i> Last <i>PIERCE</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service)		16b. SOCIAL SECURITY NO <i>219-34-7446</i>		17. INFORMANT Name <i>Joseph Daener</i> Address <i>same</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4 4</i> <i>Bronchopneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>clubbal Embolism</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>332x</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>5 1/2 months</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Generalized atherosclerosis; Nephrosclerosis, Chronic pyelonephritis</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>7-30</i> , 1968, to <i>12-22</i> , 1968, that (I) (we) lost saw the deceased alive on <i>12-22</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Edwin G. Riley</i>		22c. DATE SIGNED <i>DEC 23, 1968</i>		22d. PHYSICIAN'S NAME (Type) <i>Edwin G. Riley</i>	
22e. ADDRESS <i>Western Md. State Hospital</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Dec. 26, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Brownsville Cemetery</i>	
23d. LOCATION (City or Town) (County) (State) <i>Brownsville Wash. Md.</i>					
24. FUNERAL DIRECTOR <i>John H. Bast, Jr.</i>		ADDRESS <i>112 N. Main St, Boonsboro, Md.</i>		25a. RECEIVED BY REGISTRAR DATE <i>DEC 30 1968</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

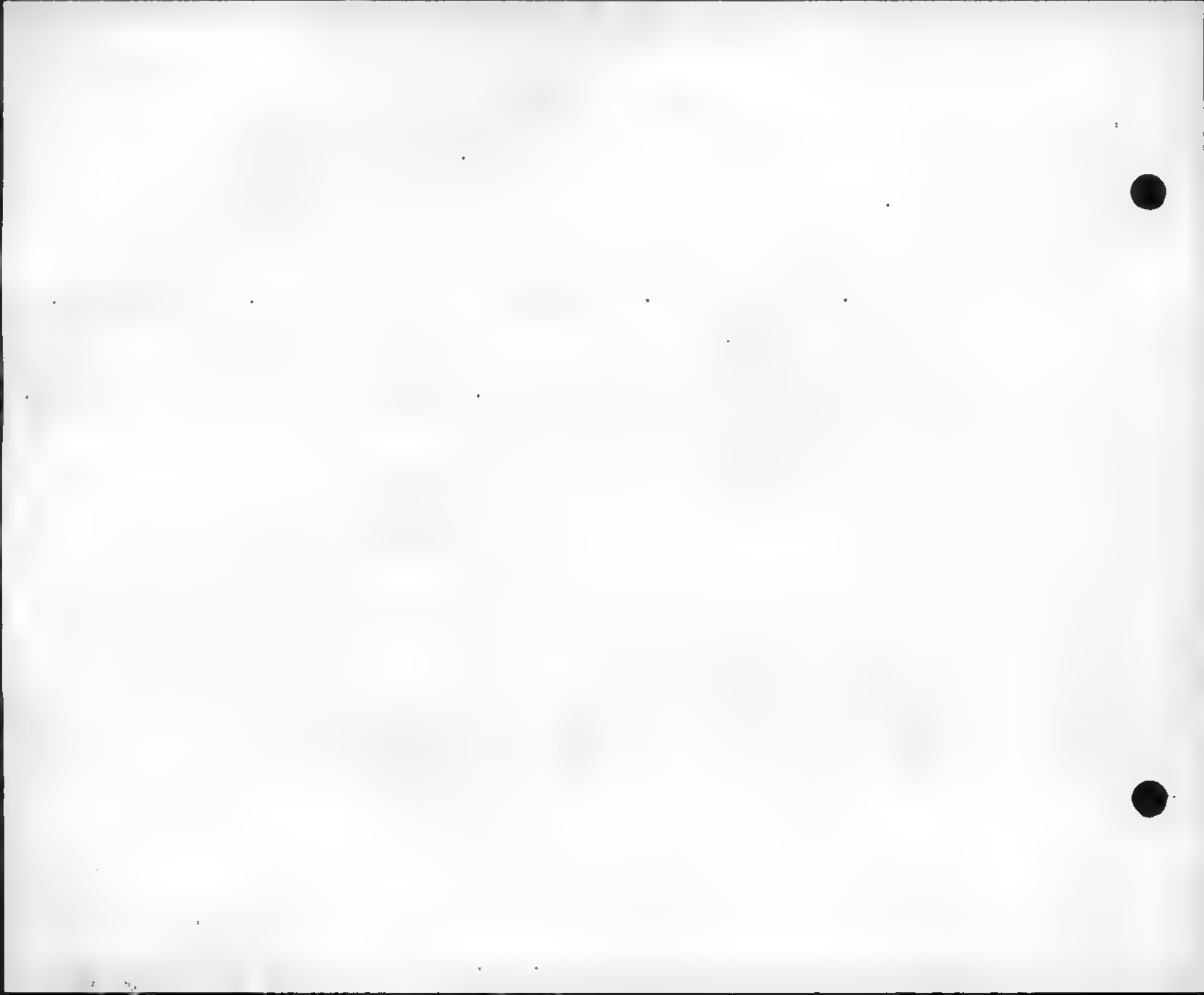


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4)
304 REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH			2b. HOUR			
Grace		Carrie		Diehl				12 Month 29 Day 68 Year			M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
male		white		Nov. 13, 1894			74 YRS.		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
Penna.		USA				Washington Md.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Williamsport			Williamsport Sanitarium			housewife								
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Md.			Wash.			Funkstown				41 E. Baltimore St.				
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				Address						
First Middle Last				First Middle Last										
Harvey Senger				Barbara Petre										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address								
no				no		Mrs. Mildred Beckley Funkstown, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Cachexia														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
(b) advanced senility														
DUE TO, OR AS A CONSEQUENCE OF														
(c) Cerebral arteriosclerosis														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
none												0		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. none 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
						none								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State				
none		none												
22a. I certify that (I) (this hospital) attended the deceased from Dec 11, 1968, to Dec 29, 1968, that (I) (we) last saw the deceased alive on Dec 12, 1968, and that in (my) (our) (our) death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE								DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
Harold R. Tritch, Jr MD												12/30/68		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS										
Harold R. Tritch, Jr MD				302 N. Potomac St Hagerstown, Md										
23a. BURIAL, CREMATION, RECOVERY (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)								
RECOVERY (Specify)		12-31-68		Rest Haven Cemetery		Hagerstown, Md.								
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE								
Minnich Funeral Home Hagerstown, Md.				JAN 3 1969		Charles Judge								



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please excuse the certificate, writing the word "pending" in parentheses. 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18355

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18368

1. DECEASED-NAME (Type or Print) HAZEL JOY EBY			2a. DATE KNOWN OF DEATH Month 12 Day 22 Year 1968			2b. DATE Month 12 Day 22 Year 1968			
3. SEX F	4. RACE W	5. DATE OF BIRTH 11/23/68	6. AGE (In years last birthday) 29	IF UNDER 1 YEAR MONTHS 29 DAYS 29	IF UNDER 24 HRS HOURS 29 MIN 29	2c. DATE PRONOUNCED DEAD Month 12 Day 22 Year 1968			
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON			
10. CITY OR TOWN OF DEATH HAG. RD 4		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hagerstown			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None		12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY WASH		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RD 4 - Hagerstown	
14. FATHER'S NAME First Nelson Middle Eby Last Eby			15. MOTHER'S MAIDEN NAME First Doris Middle Miller Last Miller			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			
16b. SOCIAL SECURITY NO. NONE			17. INFORMANT Nelson Eby - Hagerstown Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 466X IMMEDIATE CAUSE (a) SUFFOCATION DUE TO STEAM KETTLE DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE BRONCHITIS DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE BRONCHITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SHORT INTERVAL SEVERAL DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE E. W. Ditto, Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 12-22-68	
EXAMINER'S NAME (Type) DR. E.W.DITTO, JR.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE 12/24/68		23c. NAME OF CEMETERY OR CREMATORY Keith Ch. Cem.		23d. LOCATION (City or Town) (County) (State) WASH. Co., Md.			
24. FUNERAL DIRECTOR W.C. Minnick - Greencastle, Pa.				25a. REC'D BY REGISTRAR DEC 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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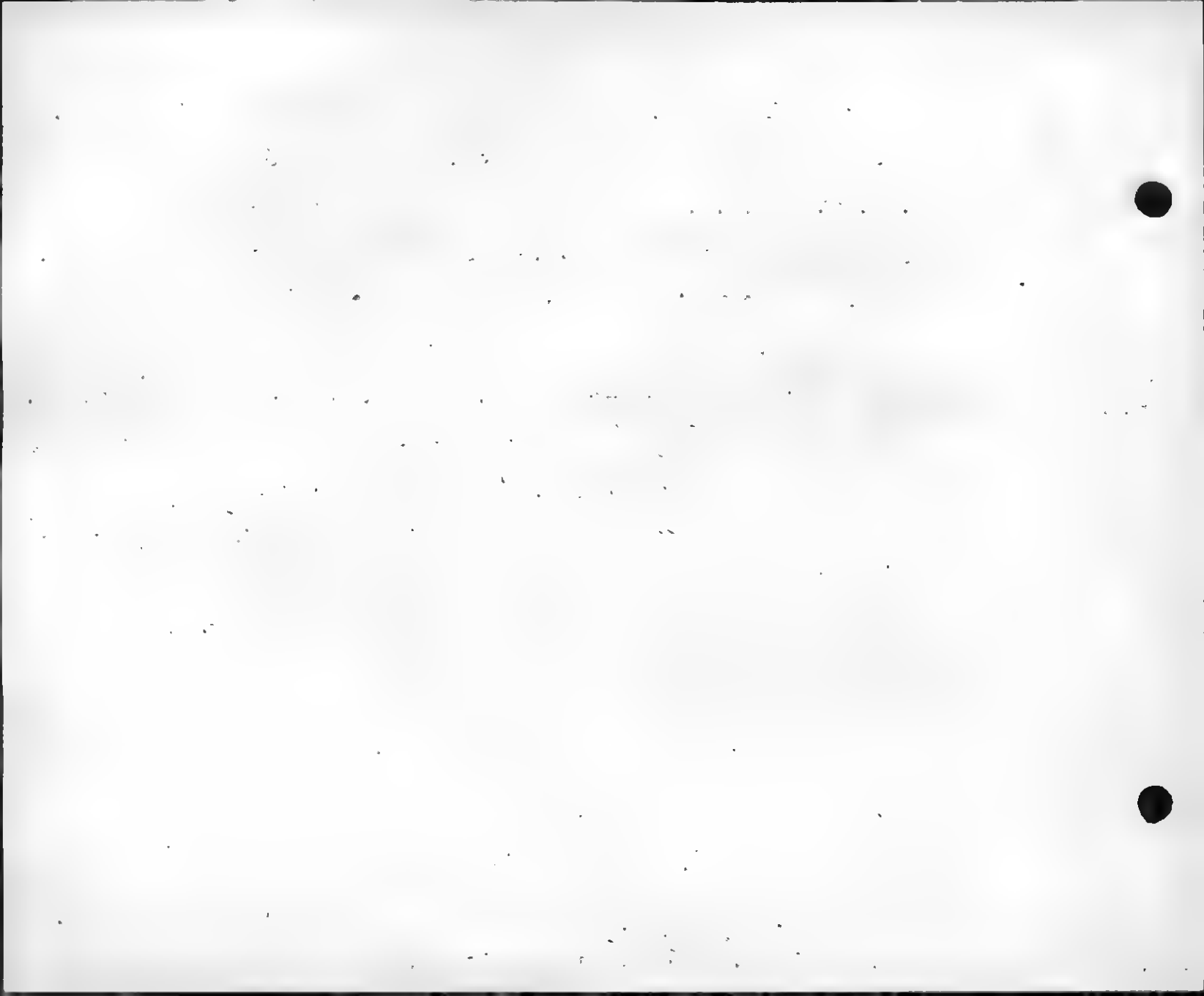
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
18356		18369										
1. DECEASED-NAME (Type or print) First Middle Last STERLING WALLACE EDWARDS						2a. DATE OF DEATH Month Day Year December 17 1968			2b. HOUR 2.30 PM			
3 SEX male		4. RACE white		5. DATE OF BIRTH Oct. 3, 1900			6 AGE (in years last birthday) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Balto. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.						
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Teacher			12b. KIND OF BUSINESS OR INDUSTRY Public Sch.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Frederick		13c. CITY OR TOWN Myersville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route # 2			
14. FATHER'S NAME First Middle Last Sterling W. Edwards				15. MOTHER'S MAIDEN NAME First Middle Last Delia Ennals Edwards								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) yes WW # 1				16b. SOCIAL SECURITY NO. 218-34-3658		17. INFORMANT Address Rt. #2 Mrs. Ellen W. Edwards, Myersville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cecchial Hemorrhage 7 days DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Metastatic Brain DUE TO, OR AS A CONSEQUENCE OF (c) Malignant Melanoma Neck July 68 1726 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 1905												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 12 Dec, 1968, to 17 Dec, 1968, that (I) (we) last saw the deceased alive on 17 Dec 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Frank E. Brumback M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 18 Dec 68		
22d. PHYSICIAN'S NAME (Type) 119 King St Hagerstown, Md												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 19, 1968		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City or Town) (County) (State) Baltimore Md.						
24. FUNERAL DIRECTOR Paul F. Bittle, Myersville, Md						25a. REC'D BY REGISTRAR DEC 23 1968		25b. REGISTRAR'S SIGNATURE Johnas Judge				

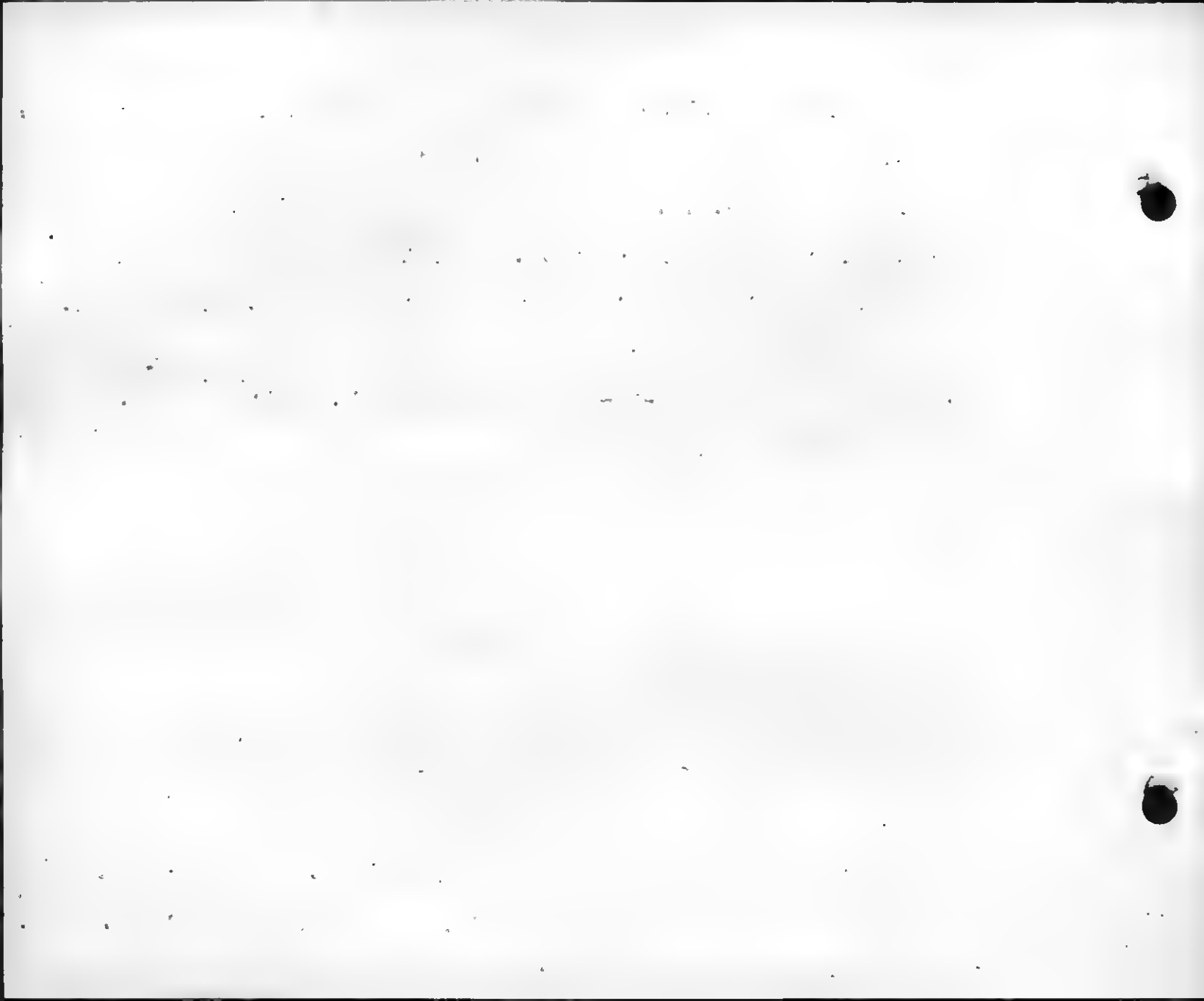


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
GLENN		ERDMAN		EYLER				DECEMBER 22 1968		10A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
MALE		WHITE		1/3/1903		65 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
PENNSYLVANIA		U.S.A.				WASHINGTON					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
HAGERSTOWN		WASHINGTON CO. HOSPITAL		TOOL MAKER		AIRCRAFT					
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
MARYLAND		WASHINGTON		HAGERSTOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		125 N. PROSPECT ST.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
EDWARD		EYLER						ELBA GRACE MINER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT				HAGERSTOWN			
NO		212-10-0932		MISS ELAINE M. EYLER				MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Anoxia</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4210 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive Heart Failure</i>										Hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)										5 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4-4											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
				700		600		2200		1968	
22a. I certify that (I) (this hospital) attended the deceased from 7:00, 1968, to 2:20, 1968, that (I) (we) last saw the deceased alive on 22 Dec 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
DR. J.D. WILSON		MD						1/23/68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
		NORTHERN AVE. HAGERSTOWN, MD									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		12/24/68		REST HAVEN CEM.		HAGERSTOWN WASH. MD.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Miss Norma Hagerstown, Md.				DATE DEC 30 1968		J. Charles Judge					

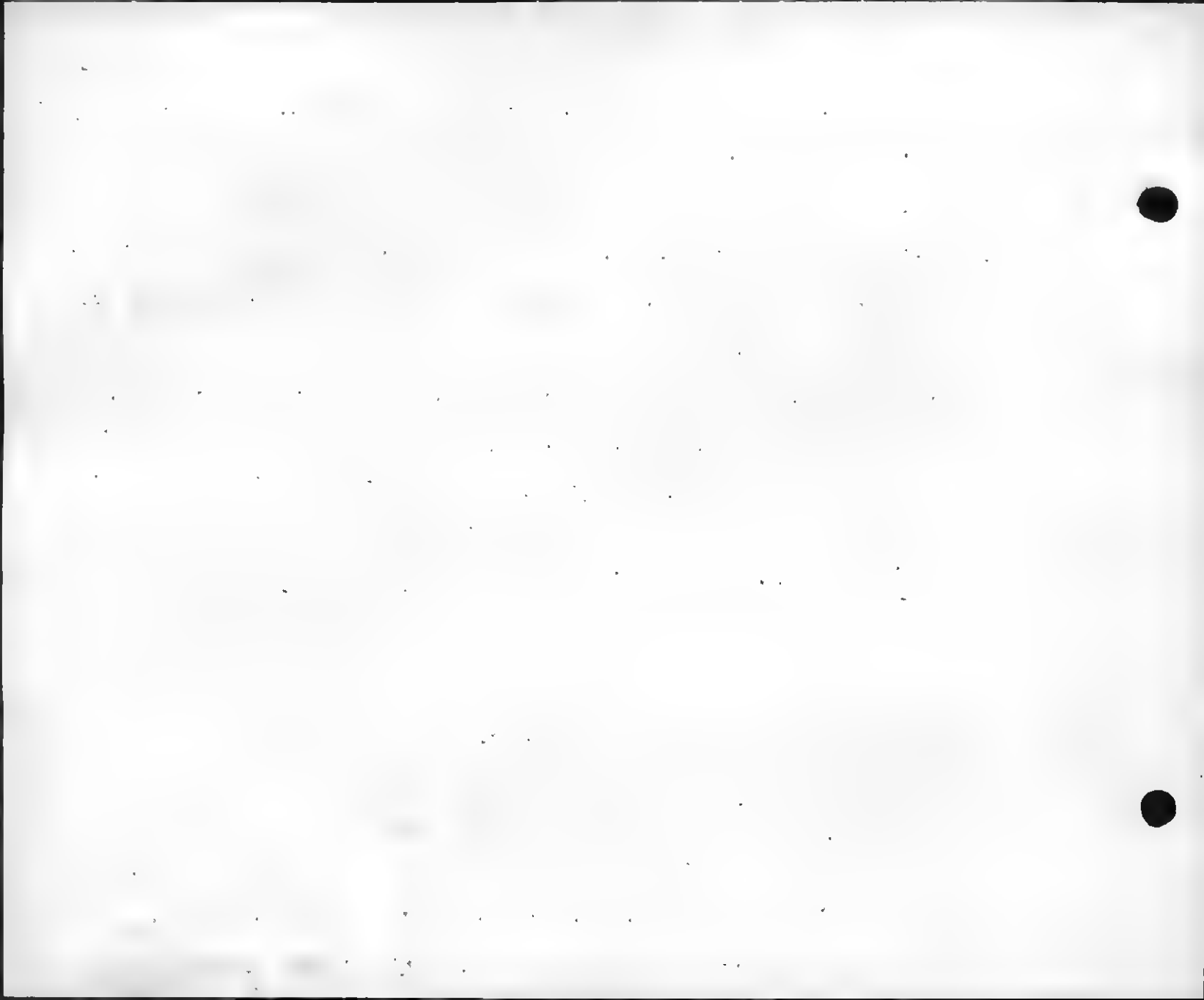


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

183358										18371														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH														
1 DECEASED NAME (Type or print) First Middle Last Jerome Vincent Faith					2a. DATE OF DEATH Month 22 Day 68 Year Dec. 22 1968					2b. HOUR 3:45 P.M.														
3. SEX male			4. RACE white			5. DATE OF BIRTH Oct. 3, 1889			6. AGE (in years last birthday) 79 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS M.N.										
7a. BIRTHPLACE (State or foreign country) Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington Md.															
10. CITY OR TOWN OF DEATH Hagerstown					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) maintenance					12b. KIND OF BUSINESS OR INDUSTRY aircraft									
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.					13b. COUNTY Wash.					13c. CITY OR TOWN Hagerstown					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
13e. STREET AND NUMBER 223 Frederick St.					14. FATHER'S NAME First Middle Last Lewis Faith					15. MOTHER'S MAIDEN NAME First Middle Last Alice M. Sagle														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes					16b. SOCIAL SECURITY NO. 217-12-1333					17. INFORMANT Leah M. Faith					Address Hagerstown, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Trauma & Complications</i> 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 151X (b) <i>Malnutrition of stomach</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Not known</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Chronic Cardiovascular Disease</i>																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 3, 1967</i> to <i>12/22, 1968</i> , that (I) (we) last saw the deceased alive on <i>12/21, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																								
22b. SIGNATURE <i>Arthur Riego</i>															22c. DATE SIGNED 12-23-68									
22d. PHYSICIAN'S NAME (Type) ARTHUR RIEGO															22e. ADDRESS 119 E. Antietam St.									
23a. BURIAL, CREMATION, REMOVAL (Specify) burial					23b. DATE 12-24-68					23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery					23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.									
24. FUNERAL DIRECTOR Minnich Funeral Home										ADDRESS Hagerstown, Md.					25a. REC'D BY REGISTRAR DEC 27 1968					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



18353

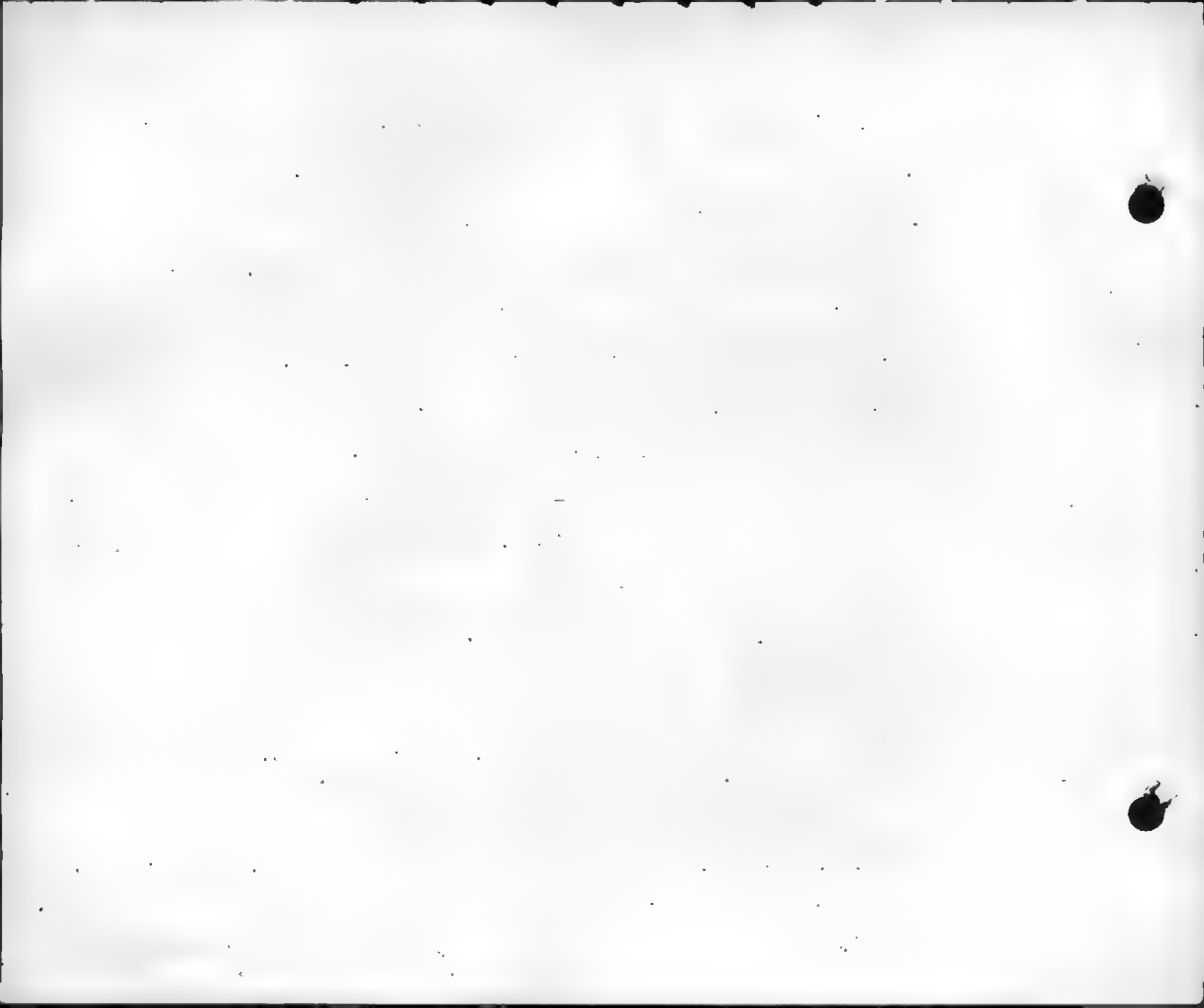
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

18372

1. PLACE OF DEATH a. COUNTY <p style="text-align: center;">Washington MARYLAND</p>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <p style="text-align: center;">Pennsylvania</p> b. COUNTY <p style="text-align: center;">Franklin</p>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <p style="text-align: center;">Hagerstown</p>		c. LENGTH OF STAY IN 1b <p style="text-align: center;">1 day</p>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <p style="text-align: center;">Washington County Hospital</p>		d. STREET ADDRESS <p style="text-align: center;">14 Center Square</p>	
3. NAME OF DECEASED (Type or print) <p style="text-align: center;">Harry Edward Finafrock</p>		4. DATE OF DEATH <p style="text-align: center;">Dec. 7, 1968</p>	
5. SEX <p style="text-align: center;">M</p>	6. COLOR OR RACE <p style="text-align: center;">W</p>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <p style="text-align: center;">May 3, 1914</p>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <p style="text-align: center;">Truck Driver</p>		9b. KIND OF BUSINESS OR INDUSTRY <p style="text-align: center;">Commercial Hauling</p>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <p style="text-align: center;">Truck Driver</p>		11. BIRTHPLACE (County & State, or foreign country) <p style="text-align: center;">Greencastle, Pa.</p>	
13. FATHER'S NAME <p style="text-align: center;">Frank B. Finafrock</p>		14. MOTHER'S MAIDEN NAME <p style="text-align: center;">Bertha E. Dale</p>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <p style="text-align: center;">No</p>		16. SOCIAL SECURITY NO. <p style="text-align: center;">164-16-5146</p>	
17. INFORMANT <p style="text-align: center;">Medical Record</p>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <p style="text-align: center;">Massive intra-abdominal hemorrhage</p> 441 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <p style="text-align: center;">(b) Rupture, abdominal aortic aneurysm</p> DUE TO <p style="text-align: center;">(c) Arteriosclerosis</p>			INTERVAL BETWEEN ONSET AND DEATH <p style="text-align: center;">12 hours</p> <p style="text-align: center;">24 hours</p>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <p style="text-align: center;">Pulmonary tuberculosis, bilateral active</p>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <p style="text-align: center;">19</p>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <p style="text-align: center;">Dec. 6, 1968</p> to <p style="text-align: center;">Dec. 7, 1968</p> , that (I) (we) last saw the deceased alive on <p style="text-align: center;">Dec. 7, 1968</p> , and that death occurred at <p style="text-align: center;">6:40 AM</p> from the causes and on the date stated above.			
22a. SIGNATURE <p style="text-align: center;">J. H. Kehne</p>		22b. DATE SIGNED <p style="text-align: center;">DEC 10 1968</p>	
22c. PHYSICIAN'S NAME (Type) <p style="text-align: center;">J. H. KEHNE, M. D.</p>		22d. ADDRESS <p style="text-align: center;">1229 Ravenwood Hts. Hagerstown, Md.</p>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <p style="text-align: center;">Burial</p>	23b. DATE THEREOF <p style="text-align: center;">12/10/1968</p>	23c. NAME OF CEMETERY OR CREMATORY <p style="text-align: center;">Parklawn Mem. Gardens</p>	23d. LOCATION (City, town or county) (State) <p style="text-align: center;">Chambersburg, Franklin Pa.</p>
24. FUNERAL DIRECTOR <p style="text-align: center;">Harold H. Zimmerman</p>		25a. REC'D BY REGISTRAR <p style="text-align: center;">DEC 10 1968</p>	
25b. REGISTRAR'S SIGNATURE <p style="text-align: center;">J. Charles Judge</p>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2, and have them filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18373

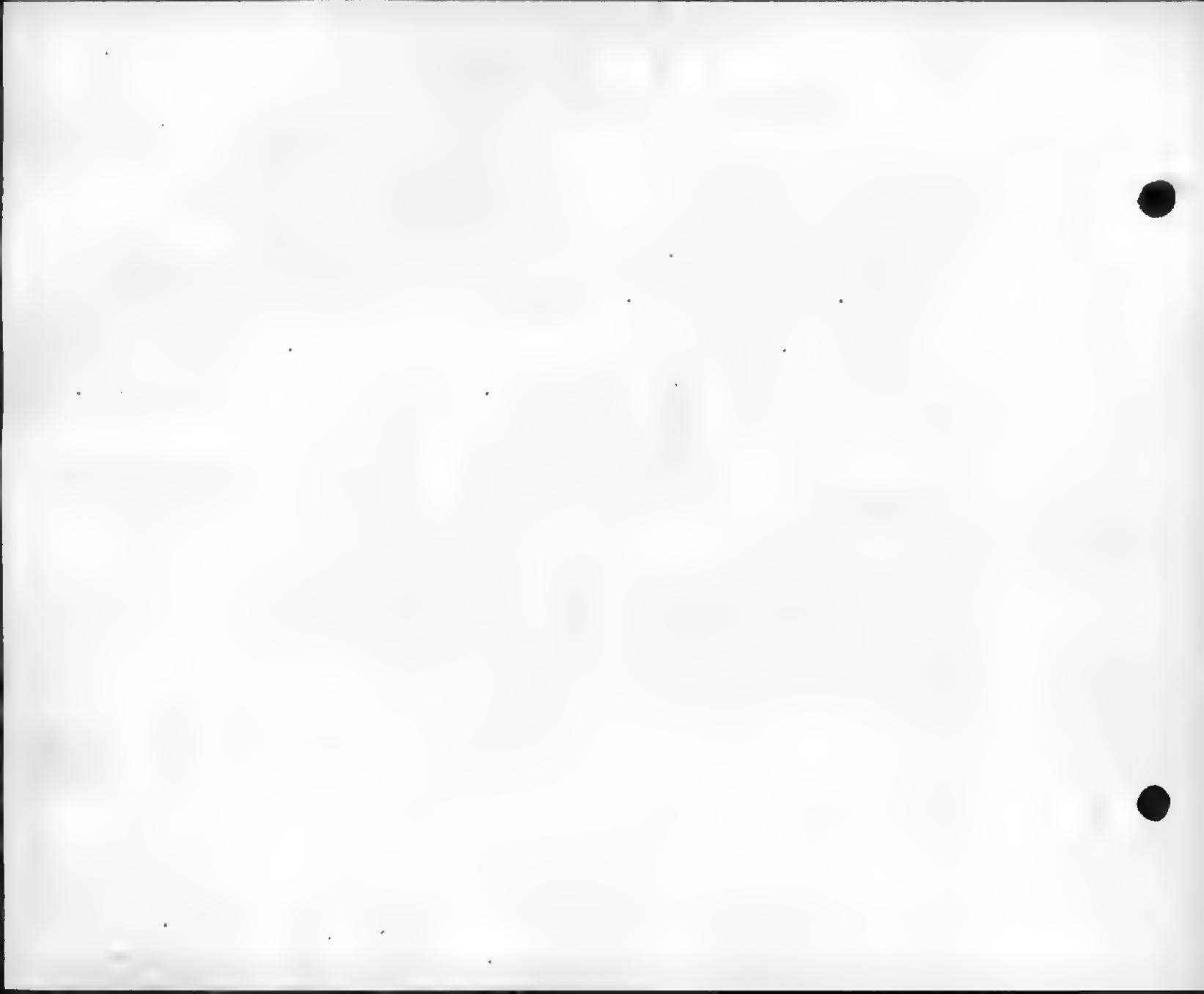
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18373

1. DECEASED NAME (Type or print) First Middle Last Charles Martin Freed			2a. DATE OF DEATH Month Day Year December 31, 1968		2b. HOUR 1:55 p.m.
3 SEX male	4 RACE white	5. DATE OF BIRTH 1-21-1907		6 AGE (In years last birthday) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Washington Md.		
10 CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. County Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) truck driver		12b. KIND OF BUSINESS OR INDUSTRY Farmers Cooperative
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INS. DE. CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 129 Harp Road
14. FATHER'S NAME First Middle Last Arthur N. Freed			15. MOTHER'S MAIDEN NAME First Middle Last Jennie F. Rudisill		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 217-32-5474		17 INFORMANT Address Mrs. Virginia Freed Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 410? DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15-20 hr					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 5-21 , 19 68 , to 12-31 , 19 68 , that (I) (we) last saw the deceased alive on Dec 28 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE E. R. Lardisack		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-3-69	
22d. PHYSICIAN'S NAME (Type) E. R. Lardisack		22e. ADDRESS 301 W. Preston Street, Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 1-3-1969		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.					
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JAN 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

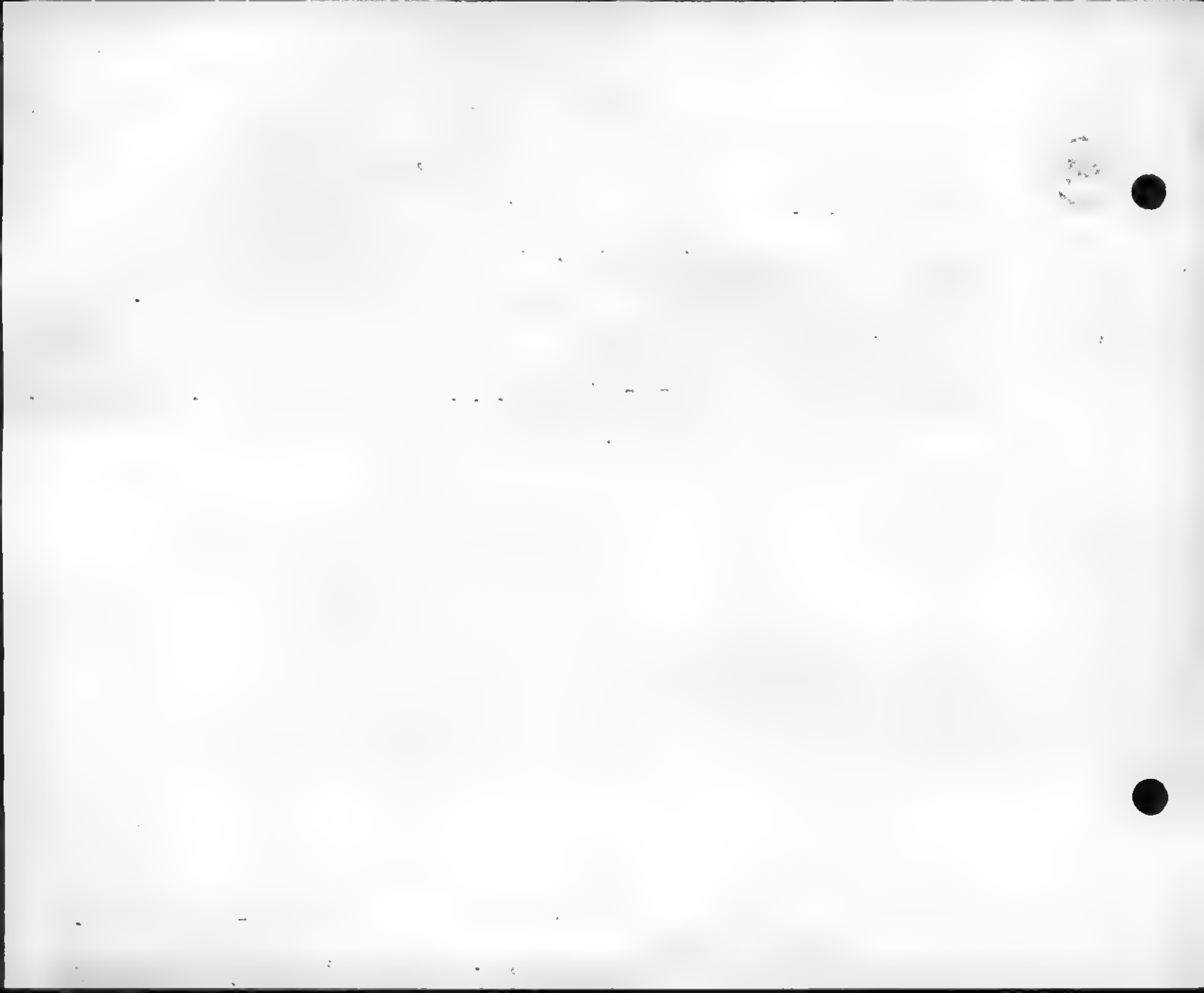
VR A15 14, 45M 1/69



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return it to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return it to the funeral director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18361												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												18374			
CERTIFICATE OF DEATH																											
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH				2b. HOUR															
Mallie				Elizabeth				Funk				December				Day 22 Year 1968 3:59 PM											
3. SEX				4. RACE				5. DATE OF BIRTH				6. AGE (In years last birthday)				IF UNDER 1 YEAR				IF UNDER 24 HRS.							
Female				White				May 30, 1882				86 YRS.				MONTHS DAYS HOURS MIN.											
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH															
Spring Valley, Va.				USA								Washington				Md.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY															
Hagerstown				Washington Co. Hospital				Housewife				Own Home															
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b. CITY OR TOWN				13c. INSIDE CITY LIM-TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13d. STREET AND NUMBER															
Maryland				Washington				Hagerstown				730 Summit Ave.															
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last																							
Fielden				Vaughn				Zilpha				Ellen				Anderson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.				17. INFORMANT				Address															
No				215-26-811491				Mrs. O.B. Funk				415 Guilford Ave. Hagerstown, Md.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ruptured Appendix												16 days															
5400 DUE TO, OR AS A CONSEQUENCE OF																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5501												(b) DUE TO, OR AS A CONSEQUENCE OF															
												(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																											
Arteriosclerotic Heart Disease																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 12/6, 1968, to 12/22, 1968, that (I) (we) last saw the deceased alive on 12/21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE				22c. DATE SIGNED																							
George Jennings				12/23/68																							
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS																							
George Jennings				318 N. Potomac St. Hagerstown Md.																							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)															
Burial				12/24/68				Rest Haven Cemetery				Hagerstown-Washington-Md.															
24. FUNERAL DIRECTOR				24b. ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE															
Rest Haven Funeral Chapel				Hagerstown, Md.				DATE DEC 27 1968				J. Charles Judge															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR A
MARGARET		Mary		GILFORD		December 2 1968			2.30 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH Oct. 2, 1909			6. AGE (In years last birthday) 59 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington Md.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Avalon Manor			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Bookkeeper			12b. KIND OF BUSINESS OR INDUSTRY Hotel			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 544 Chestnut St.			
14. FATHER'S NAME First Middle Last Joseph -- Conway		15. MOTHER'S MAIDEN NAME First Middle Last Florence -- McKenzie									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 216-22-5422		17. INFORMANT William P. Gilford Address 544 Chestnut St. Hagerstown Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intracerebral Hemorrhage											
431.7 DUE TO, OR AS A CONSEQUENCE OF (b) Convulsion.											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
351X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 10-2, 1968, to --, 19--, that (I) (we) last saw the deceased alive on 10-2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles C. Spencer		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12-2-68					
22d. PHYSICIAN'S NAME (Type) Charles C. Spencer, M.D.		22e. ADDRESS 145 S. Prospect St.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/4/68		23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.					
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumberland, Maryland		25a. RECD BY REGISTRAR DEC 6 1968		25b. REGISTRAR'S SIGNATURE H. Wayne George					

MEDICAL CERTIFICATION

CONFIDENTIAL

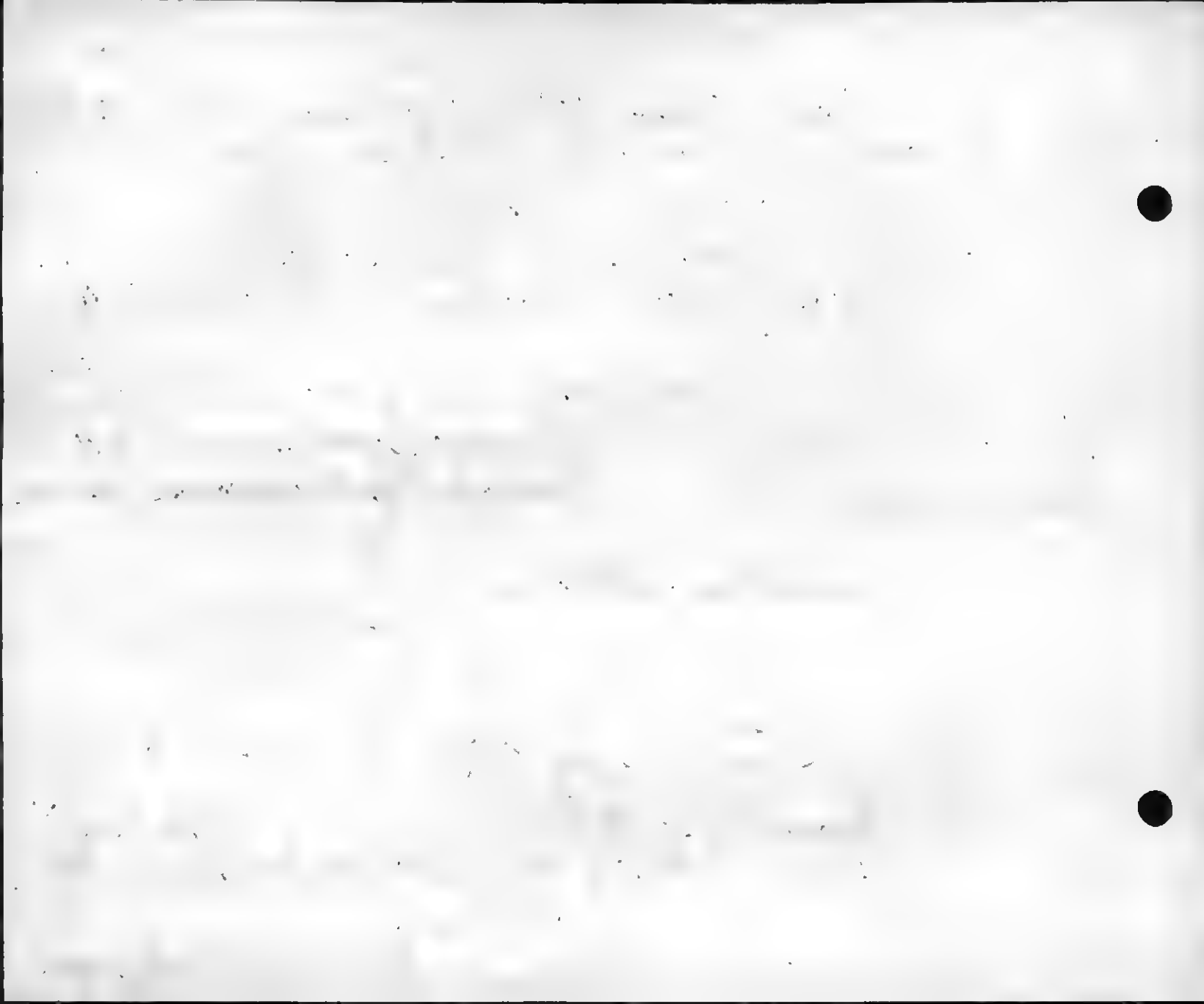
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A19-4
30M REV. 1/68

18376										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
John David Grimsley						Dec Month 23 Day 1968 Year		8:55 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		White		3/8/90		78 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Va		U.S.A.				WASHINGTON				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
HAGERSTOWN			WESTERN MD. STATE HOSPITAL			RETIRED STOCKMAN		MACHINE MFG.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md			Wash		Hagerstown		YES <input type="checkbox"/> NO <input type="checkbox"/>		1207 Glenwood Ave	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
John Butler Grimsley			MARY Lee							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
No			214-09-3818A		HAROLD E. Grimsley		1207 Glenwood Ave Hagerstown Md 21740			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Lobular pneumonia									3d	
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis									years	
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Diabetes mellitus										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year								
		P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		
22a. I certify that (I) (this hospital) attended the deceased from 8-21, 1967, to 12-23, 1968, that (II) (we) last saw the deceased alive on 12-23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						DEGREE		22c. DATE SIGNED		
Edwin G. Riley MD						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		12-23-68		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
Edwin G. Riley MD						1500 Penna. Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
Burial		12/27/68		Rest Haven Cemetery		Hagerstown		Wash. Md		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Charles M. Kauger						DATE DEC 30 1968		Charles Judge		
305 N. Potomac St.										

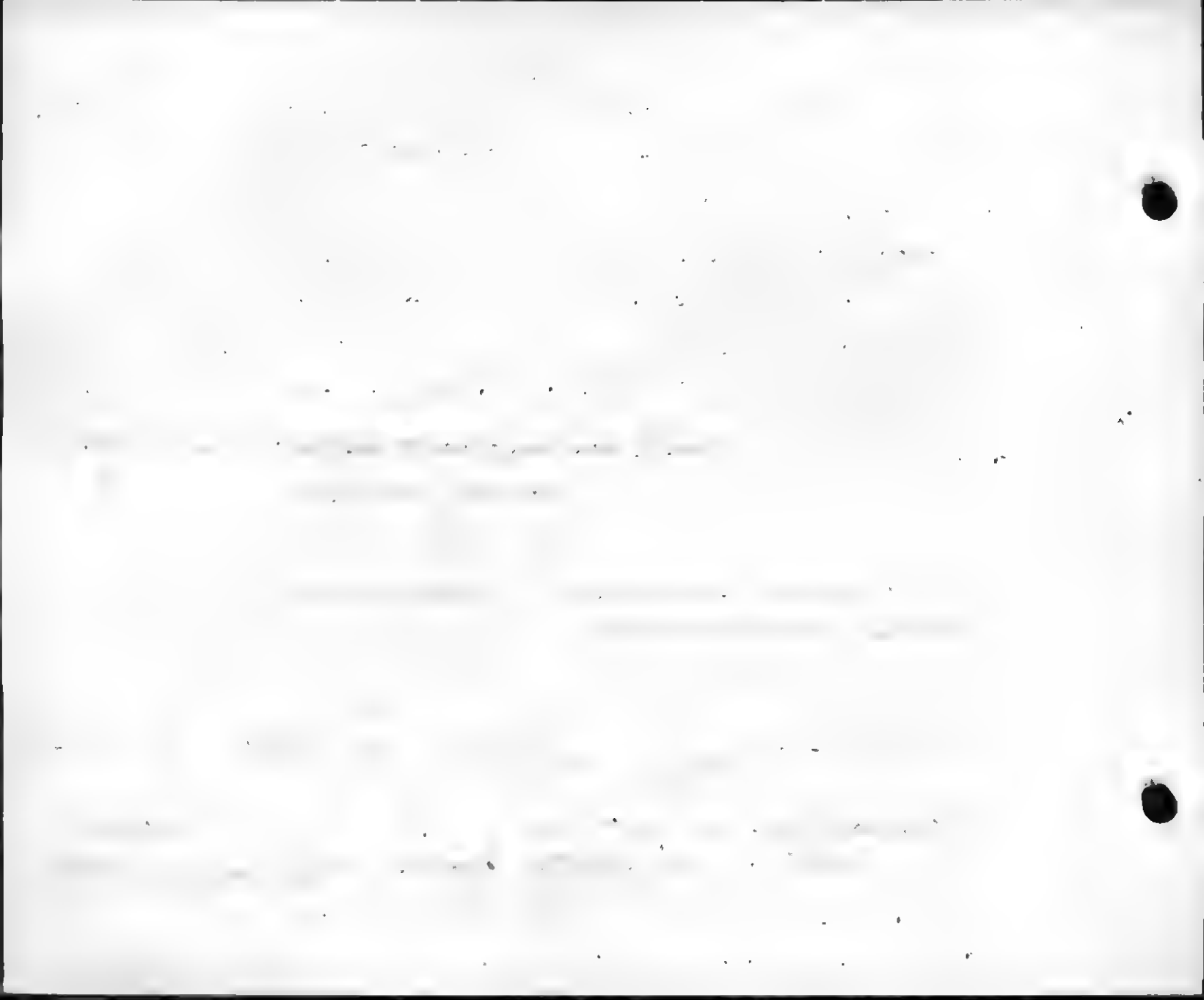


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires, that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>18364</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>18377</div>																	
1. DECEASED-NAME (Type or print)			First Elmer			Middle Glen			Last Gunderman			2a. DATE OF DEATH Month December 13, 1968			2b. HOUR 10:50 A.M.		
3 SEX male			4 RACE white			5. DATE OF BIRTH 11-30-1890			6 AGE (In years last birthday) 78 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN		
7a BIRTHPLACE (State or foreign country) Pennsylvania			7b CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Washington Md								
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. County Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Accountant			12b KIND OF BUSINESS OR INDUSTRY Fruit Growers								
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b COUNTY Wash.			13c CITY OR TOWN Hagerstown			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 228 Mealey Pkwy					
14. FATHER'S NAME First George Middle Gunderman Last			15 MOTHER'S MAIDEN NAME First Margaret Middle Voelkel Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no						16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 209-03-8024A			17 INFORMANT Address Mrs. Mary Gunderman Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive hemorrhage from esophageal varices DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis of liver DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 5870												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic cardiac disease - Nephrosclerosis																	
19a DATE OF OPERATION 12/8/68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Upper GI. hemorrhage			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 12/8, 1968, to 12/13, 1968, that (I) (we) last saw the deceased alive on 12/13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Omar D. Sprecher, Jr. M.D. DEGREE												ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12/14/68		
22d. PHYSICIAN'S NAME (Type) OMAR D. SPRECHER, Jr.												22e. ADDRESS 229 Ravenwood Hgts, Hagerstown, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12-16-68			23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			23d LOCATION (City or Town) (County) (State) Hagerstown, Md.								
24 FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.						ADDRESS			25a. REC'D BY REGISTRAR DATE DEC 16 1968			25b REGISTRAR'S SIGNATURE Charles Judge					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1/68

18378													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
Item 6 Film 408 1/8/69 kk													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
KATHERINE SMITH HAGER						Month Day Year			8:15p AM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS		
FEMALE		WHITE		JULY 21, 1881			86 87 YRS		MONTHS DAYS HOURS MIN				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
MARYLAND			U.S.A.						WASHINGTON				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
HAGERSTOWN			JACKSON CONV. HOME			HOMEMAKER			OWN HOME				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
MARYLAND			WASHINGTON			HAGERSTOWN			YES			9 N. POTOMAC ST.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
JOHN OSCAR SMITH			SARAH C WALTER										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			9. Address				
NO						MRS. J WM. GARVER			N. POTOMAC ST. HAGERSTOWN, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
(b) <u>450X</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
450X													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) <u>did not</u> attend the deceased from <u>3/22/54</u> , 19 <u>54</u> , to <u>12/26</u> , 19 <u>68</u> , that (I) <u>did</u> last saw the deceased alive on <u>10/17</u> , 19 <u>68</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS				
<u>Howard N Weeks</u>			12/27/68			HOWARD N WEEKS, M.D.			580 NORTHERN AVE., HAGERSTOWN, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
BURIAL			12/30/68			ROSE HILL CEMETERY			HAGERSTOWN, WASHINGTON, MD.				
24. FUNERAL DIRECTOR			25a. RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
<u>Charles M. Pauson</u>			HAGERSTOWN, MARYLAND			JAN 2 1969			<u>Charles Judge</u>				

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18376

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13379

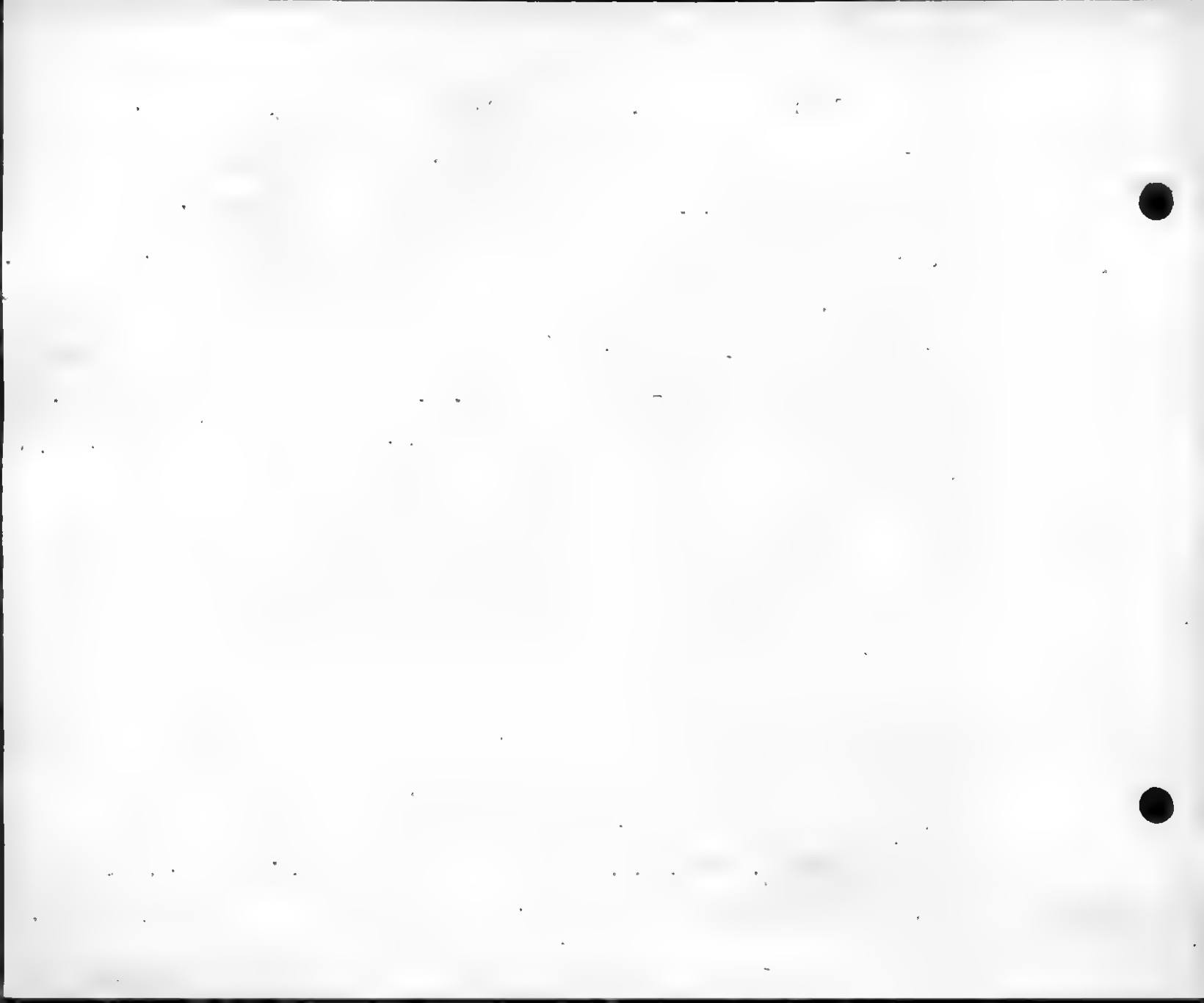
1. DECEASED-NAME (Type or Print) Orpah			First Ann			Middle 2			Last Hague			2a. DATE KNOWN OF DEATH Month 12 Day 20 Year 1968			2b. HOUR OF DEATH 12:45 PM				
3 SEX female		4. RACE white		5. DATE OF BIRTH 4-19-1883		6. AGE (in years last birthday) 85 YRS.		7. UNDER YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD Month 12 Day 20 Year 1968			2d. HOUR 12:45 PM				
7a. BIRTHPLACE (State or foreign country) Pennsylvania				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Washington Md							
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. County Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Home							
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.				13b. COUNTY Wash.				13c. CITY OR TOWN Hagerstown				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1630 Dual Hwy					
14. FATHER'S NAME Benjamin Brown						15. MOTHER'S MAIDEN NAME Anna Gans													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16b. SOCIAL SECURITY NO (If yes, give war or dates of service) None						17. INFORMANT Mrs. Imogene Romesburg Hagerstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of Gastric Contents 4109 DUE TO, OR AS A CONSEQUENCE OF Secondary to: (b) Myocardial Infarction + Fracture DUE TO, OR AS A CONSEQUENCE OF lost. (c) at home												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Less 1 hr. 2-4 days 6 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 9:20 AM - Dec 15, 1968				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) Fell at home											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) Home				21f. LOCATION Street or RFD No. City or Town County State 1630 Dual Hwy Hagerstown Wash Md											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Edward W. Ditto, III, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED 12-20-68							
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
						ADDRESS (Street, city, town, or county) 217 W. Washington St. Hagerstown, Maryland													
23a. BURIAL, CREMATION REMOVAL (Specify) Burial				23b. DATE 12-20-68				23c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery				23d. LOCATION (City or Town) (County) (State) Smithfield, Penna.							
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.						ADDRESS						25a. REC'D BY REGISTRAR DEC 23 1968				25b. REGISTRAR'S SIGNATURE Charles J. [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

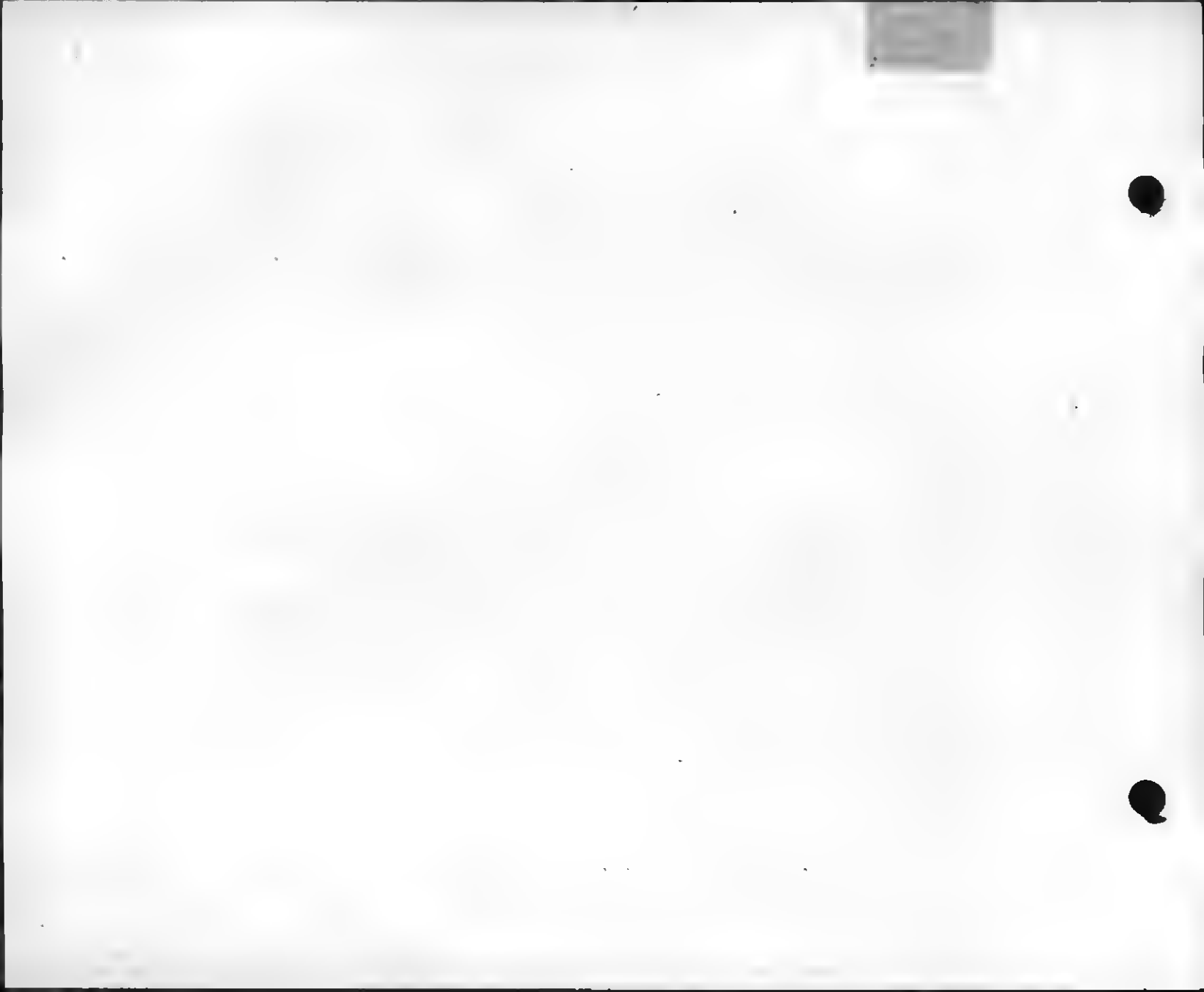
<div style="display: flex; justify-content: space-between;"> 18367 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 18380 </div> <div style="text-align: center;"> CERTIFICATE OF DEATH </div>																
1. DECEASED-NAME (Type or print)			First Glenn			Middle A.			Last Hartman			2a. DATE OF DEATH Month Dec Day 16 Year 1968			2b. HOUR 6 A. M.	
3. SEX male			4. RACE white			5. DATE OF BIRTH 4/30/09			6. AGE (In years last birthday) 59 YRS.			IF UNDER 1 YEAR MONTHS 59 DAYS 16		IF UNDER 24 HRS HOURS 6 MIN. A. M.		
7a. BIRTHPLACE (State or foreign country) Waynesboro Pa.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington Md.							
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machinist			12b. KIND OF BUSINESS OR INDUSTRY Glideline Co.							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Penna.			13b. COUNTY Franklin			13c. CITY OR TOWN Rouzeville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER				
14. FATHER'S NAME First Harry Middle D. Last Fisher			15. MOTHER'S MAIDEN NAME First Cora Middle Hershey Last Hershey													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO 195-16-2878			17. INFORMANT Mrs. B. Irene Hartman, Rouzeville Pa.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung (Bronchogenic) DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 16-1																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from 8-12 , 19 68 , to 12-16 , 19 68 , that (I) (we) last saw the deceased alive on 12-16 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Dalton M. Welty, M.D.														22c. DATE SIGNED 12/17/68		
22d. PHYSICIAN'S NAME (Type) Dalton M. Welty, M.D.			22e. ADDRESS 998 Potomac Ave. Hagerstown, Maryland													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12/18/68			23c. NAME OF CEMETERY OR CREMATORY Harbaugh's			23d. LOCATION (City or Town) (County) (State) Franklin Pa.							
24. FUNERAL DIRECTOR David Z. Grove, Waynesboro Pa.						25a. REC'D BY REGISTRAR DATE DEC 23 1968			25b. REGISTRAR'S SIGNATURE Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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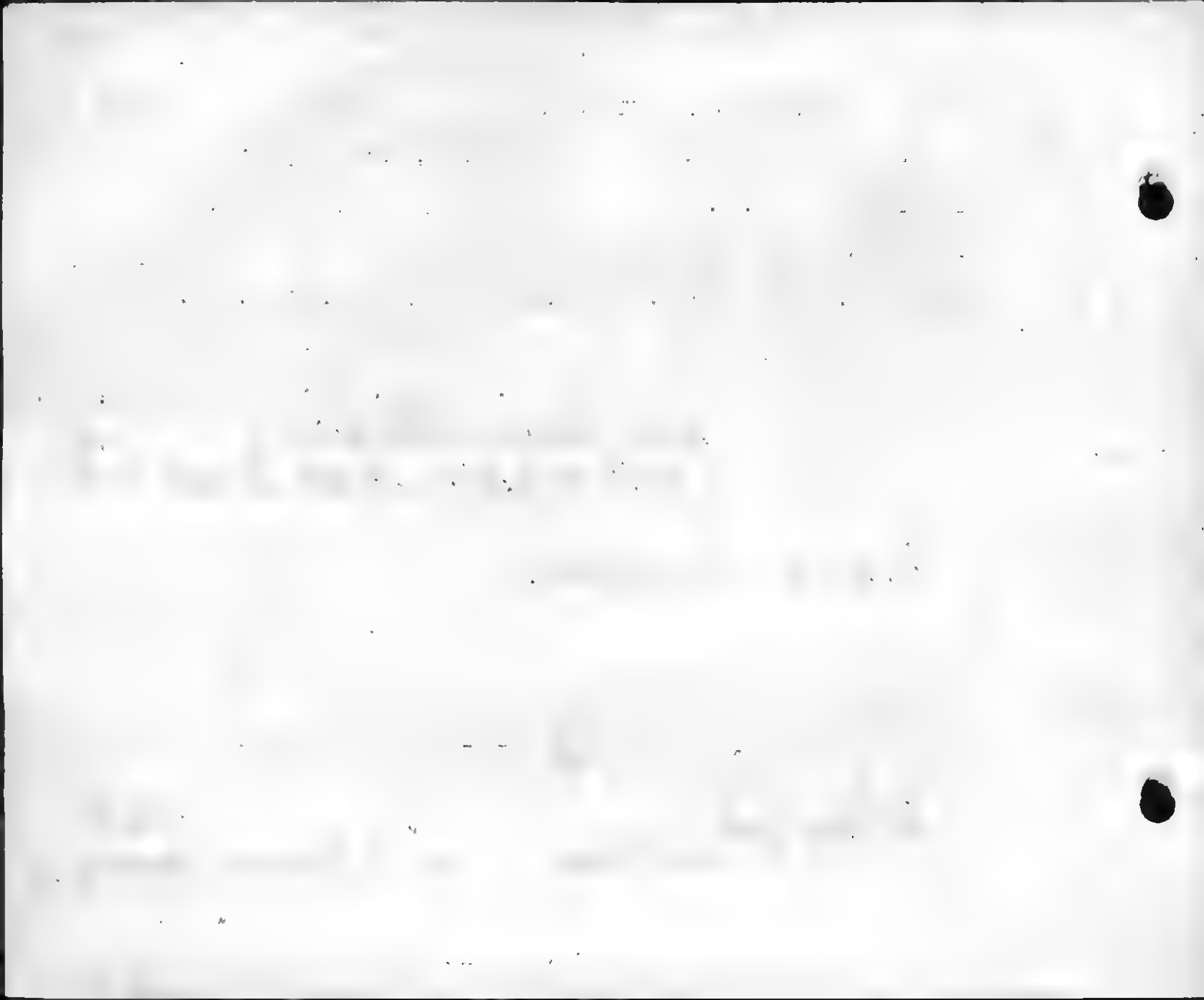
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
JOHN IEROY HARTZELL						DECEMBER Month 8 Day 68 Year			1:15pm
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR
MALE		WHITE		JANUARY 15, 1891			77 YRS.		IF UNDER 24 HRS.
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
ILLINOIS		U.S.A.					WASHINGTON Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
HAGERSTOWN			JACKSON CONV. HOME			RETIRED SUPT. OF STORES			W.M.R.R.
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?
MARYLAND			WASHINGTON			HAGERSTOWN			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e STREET AND NUMBER			
First Middle Last			First Middle Last			811 FORREST DRIVE			
JOHN MILTON HARTZELL			MARGARET O'BRIEN HARTZELL						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			811 Address
NO			705-10-5674			MRS. MARIE HARTZELL			FORREST DRIVE HAGERSTOWN, MARYLAND
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Pneumonitis</u>									2 day's
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Cerebral arterio sclerosis</u>									3 years
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Arterio sclerotic cardio vascular disease</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a))									
4129									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			HOUR A.M. Month Day Year						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from <u>2-1-67</u> , 19 <u> </u> , to <u>12-8-68</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>12-8-68</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE									22c DATE SIGNED
<u>E. W. DITTO JR., M.D.</u>									12/9/68
22d. PHYSICIAN'S NAME (Type)									22e. ADDRESS
E. W. DITTO JR., M.D.									215 W WASHINGTON ST., HAGERSTOWN, MD.
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
BURIAL			12/11/68			ROSE HILL CEMETERY			HAGERSTOWN, WASHINGTON, MD.
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
<u>Charles M. Reuser</u>			HAGERSTOWN, MARYLAND			DATE <u>DEC 13 1968</u>			<u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH Dec. 22, 1968 11:30 A.M.										
1. DECEASED-NAME (Type or print)			First Middle Last			2. DATE OF DEATH		2b HOUR		
EARL SAMUEL HOLLINGER						MPC Month 22 Day 1968		11:30 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE		WHITE		JULY 30, 1896		72 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
PENNSYLVANIA		U. S.				WASHINGTON COUNTY		Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
HAGERSTOWN			WASHINGTON COUNTY			Building Contractor		retired		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.			WASH.		HAGERSTOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2377 PA. AVE.	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last						
Samuel B. Hollinger				Alice V. Sanders						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT				
no				217 01 8432		A. Arabel Hollinger 2377 Pa. Ave. Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>+109</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>unknown</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1. Atherosclerosis</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (we) medical attended the deceased from 5-20-68, 19, to 12-22-68, 19, that (I) (we) last saw the deceased alive on 12-22-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>E.R. Landigabak</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>12-25-68</u>		
22d. PHYSICIAN'S NAME (Type) <u>E.R. Landigabak</u>						22e. ADDRESS <u>2377 Pa. Ave. Hagerstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		12/26/68		Chester Cemetery		Chestertown, Md.				
24. FUNERAL DIRECTOR <u>J. C. Wells</u>				ADDRESS <u>Chestertown, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 30 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		



FOR STATE HEALTH-DEPT.

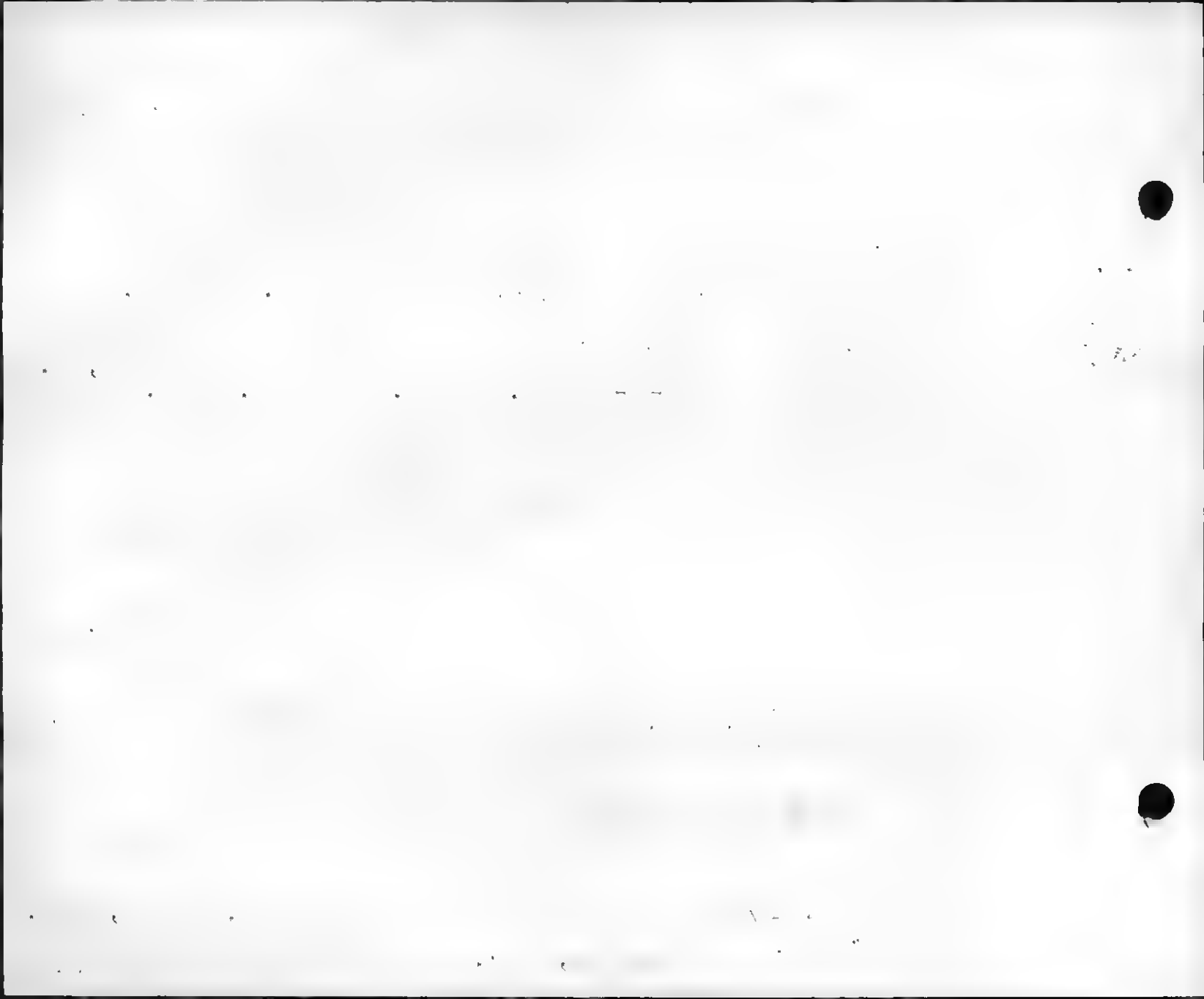
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18383

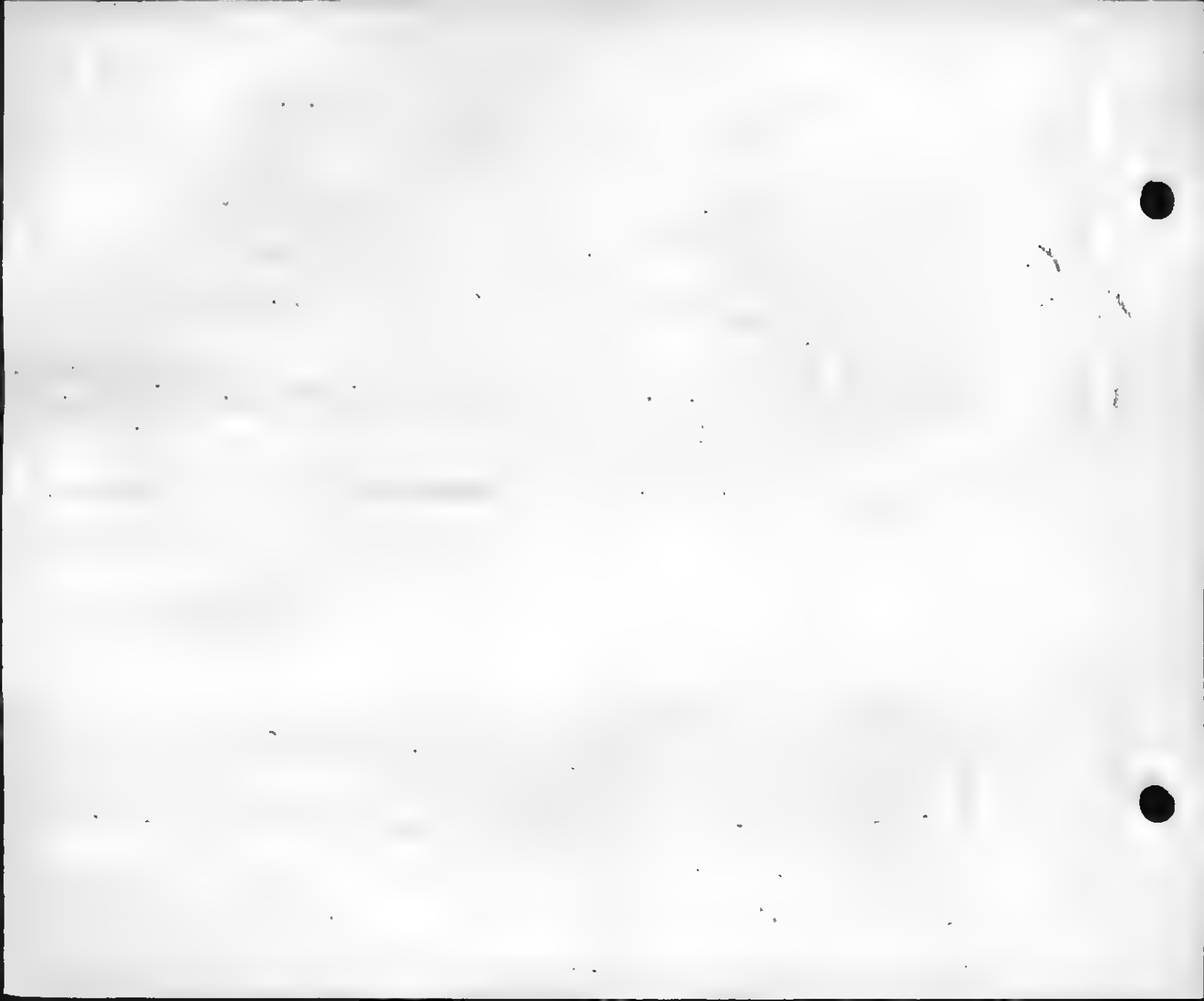
1. DECEASED-NAME (Type or Print) Frederick Robert Hollingsworth			2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> 12 11 1968			2b. HOUR 4:25 PM		
3 SEX M	4. RACE W	5. DATE OF BIRTH 9/28/46	6. AGE (In years last birthday) 22 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month 12 Day 11 Year 1968		
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington County Md.		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Labor		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Pennsylvania		13b. COUNTY Franklin		13c. CITY OR TOWN Waynesboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 514 W. Seventh St.
14. FATHER'S NAME First Middle Last Charles Hollingsworth			15. MOTHER'S MAIDEN NAME First Middle Last Nettie Reed			ADDRESS Waynesboro, Pa.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 164-34-1733		17. INFORMANT Mr. Robert F. Reed				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pending Autopsy Report</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Post surgery for replacement of bone flap</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>cervical trauma following an auto accident</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sev. days Dec. 10, 1968 9/15/68								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8254								
19a. DATE OF OPERATION 9/15/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 9/15 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) AUTO ACCIDENT				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) LOCALITY North St		21f. LOCATION Street or R.F.D. No HAGERSTOWN		City or Town MD		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Harold G. Gure		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/11/68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/13/1968		23c. NAME OF CEMETERY OR CREMATORY Burns Hill		23d. LOCATION (City or Town) (County) (State) Waynesboro, Franklin, Penna.		
24. FUNERAL DIRECTOR Harold G. Gure		ADDRESS Waynesboro, Penna.		25a. REC'D BY REGISTRAR DEC 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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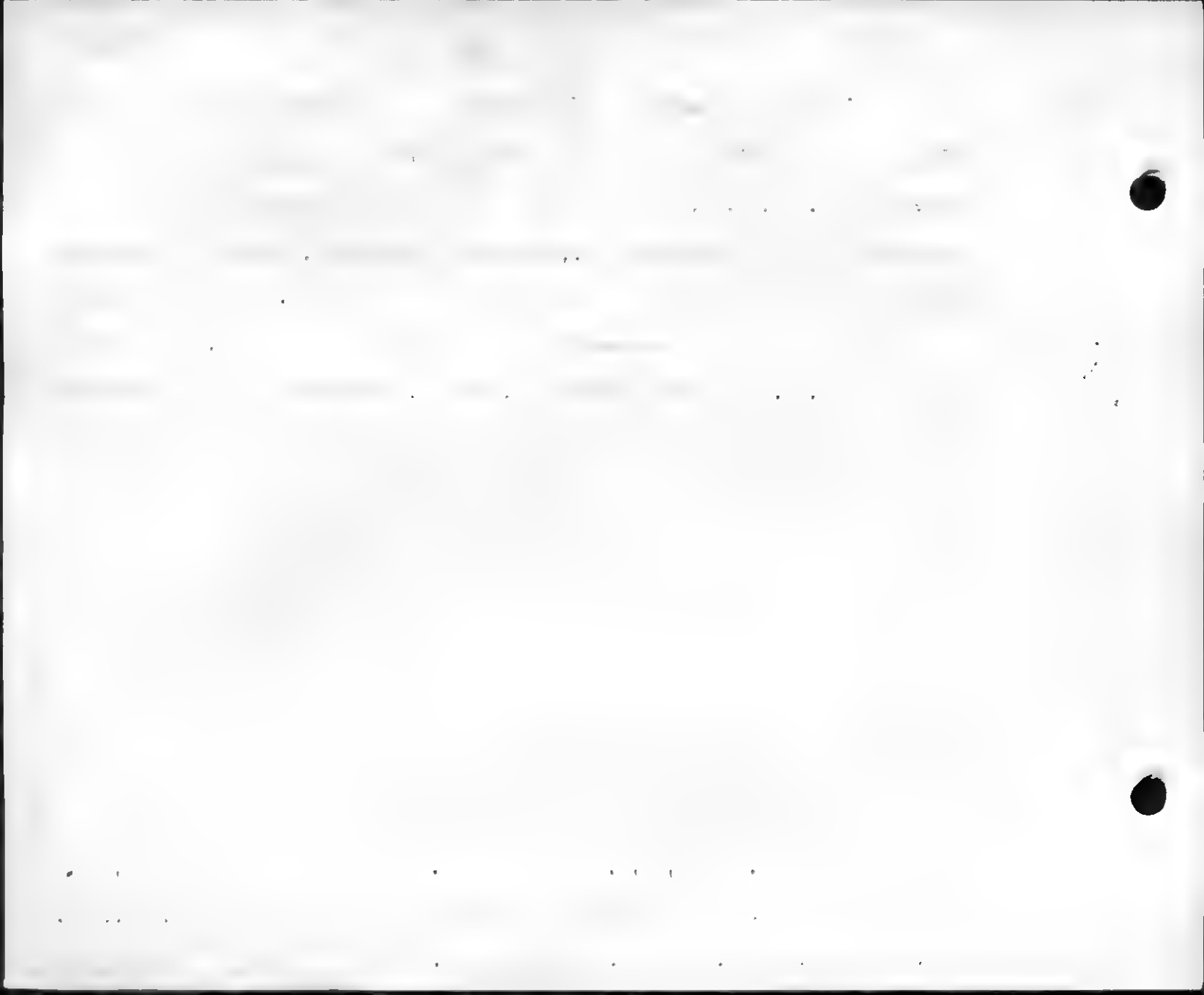
<div>18371</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>18384</div>											
1. DECEASED NAME (Type or print) JOHANNES			First Middle Last			2a. DATE OF DEATH 12.9.68			2b. HOUR 3 p M		
3 SEX MALE			4 RACE WHITE			5. DATE OF BIRTH DEC.23, 1891			6. AGE (in years last birthday) 76 YRS		
7a. BIRTHPLACE (State or foreign country) HOLLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH WASHINGTON Md.		
10. CITY OR TOWN OF DEATH HANCOCK			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED NAVY			12b. KIND OF BUSINESS OR INDUSTRY NAVY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY WASHINGTON			13c. CITY OR TOWN HANCOCK			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME First Middle Last NOT KNOWN			15. MOTHER'S MAIDEN NAME First Middle Last NOT KNOWN			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 066.07 1165		
17 INFORMANT SERENA P HOOGERWERF			Address HANCOCK MD. N.PENNA AVE.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min 20 yrs.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING NO <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6/19/59 , 19 59 , to 12/9/68 , 19 68 , that (I) (we) last saw the deceased alive on 10/22 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE FB Thomas III M.D.			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12/9/68		
22d. PHYSICIAN'S NAME (Type) FB Thomas III M.D.			22e. ADDRESS								
23a. BURIAL, CREMATION, or other disposition (Specify) CREMATION			23b. DATE 12.13.68			23c. NAME OF CEMETERY OR CREMATORY Lee's Cremaory			23d. LOCATION (City or Town) (County) (State) Washington, D.C. 20002		
24. FUNERAL DIRECTOR Howard J Stone Hancock Md			ADDRESS			25a. REC'D BY REGISTRAR DATE DEC 16 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18372										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										18385									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last Wilbur Earl Huntzberry										December 8, 1968										Year 1:00A M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS														
Male			White			April 9, 1921			47 YRS			MONTHS DAYS HOURS MIN			MONTHS DAYS HOURS MIN														
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
Pondsville, Md.					U. S. A.										Washington Md.														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Hagerstown					Washington Co., Hospital					Sanding Rm. Foreman					Furniture														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER									
Maryland					Washington					Hagerstown					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					Rfd. 1									
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																								
Frank B. Huntzberry					Bertha M. Showe																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
Yes					W. W. Two					Mrs. Mary M. Huntzberry, Rfd. 1, Hagerstown, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis - Pontine hemorrhage</u> 36 hours															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
4200 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u> unknown																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIB. TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypertensive Cardiovascular Disease</u>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or RFD. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from Dec 7, 1968 to Dec 8, 1968, that (I) (we) last saw the deceased alive on Dec 7, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.																													
22b. SIGNATURE <u>Edson B. Moody, M.D.</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>															22c. DATE SIGNED <u>12/9/68</u>														
22d. PHYSICIAN'S NAME (Type) <u>Edson B. Moody, M.D.</u>															22e. ADDRESS <u>363 S. Cleveland Ave. Hagerstown, Md.</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					12- 10- 68					Rest Haven Cemetery					Hagerstown, Wash. Co., Md.														
24. FUNERAL DIRECTOR ADDRESS															25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE									
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.															DEC 12 1968					<u>Charles Judge</u>									

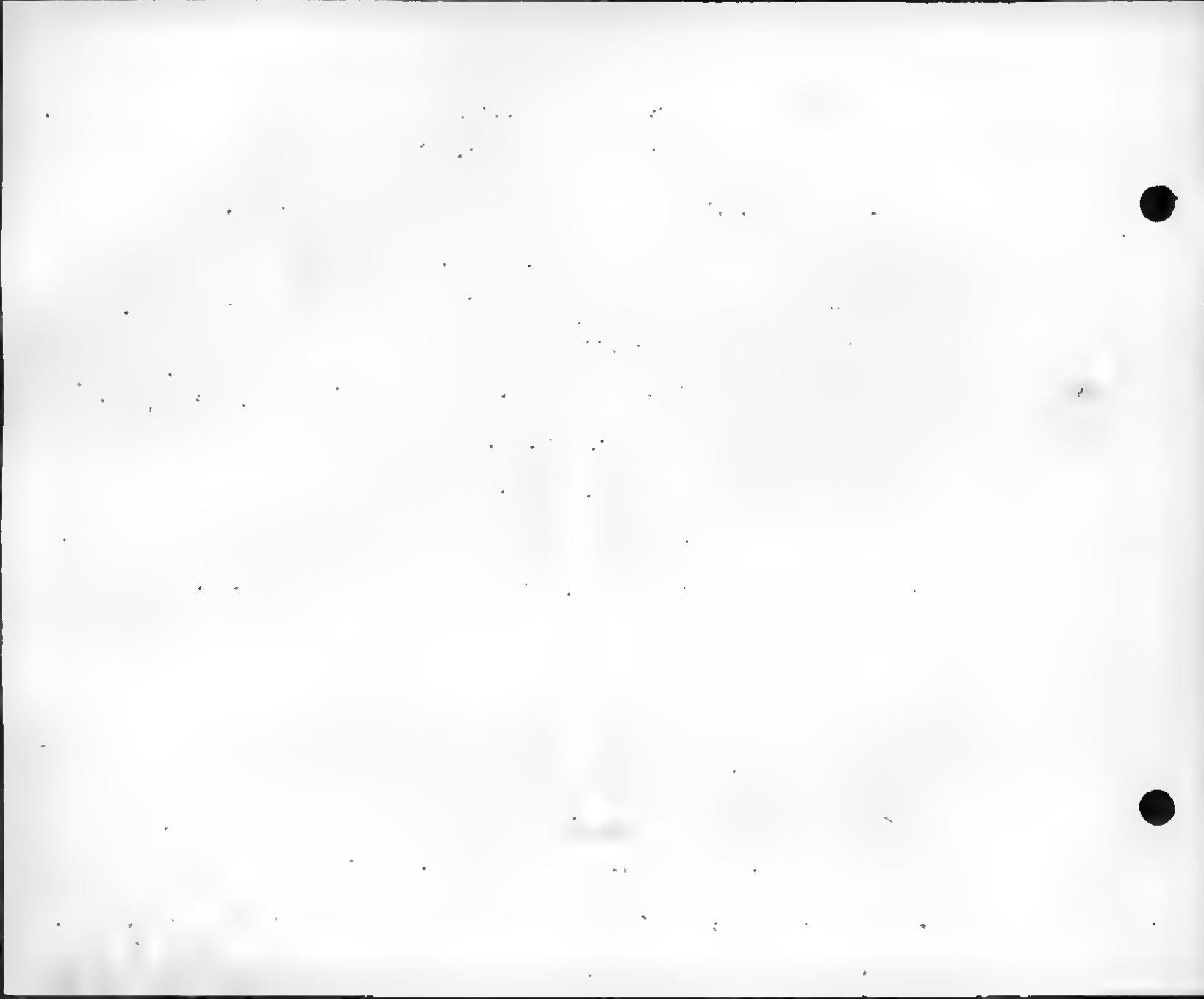


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18373		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		18386	
Item 5 Film G408 1/9/69 TS					
1. DECEASED NAME (Type or print) First Middle Last Edward Lee Hutzell			2a. DATE OF DEATH Month Day Year Dec. 30 1968		2b. HOUR 4. AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH June 27 1876 1896		6. AGE (in years last birthday) 72 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington		Md.
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 109 Stouffer Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Woodworker	
12b. KIND OF BUSINESS OR INDUSTRY Pangborn Corp					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 109 Stouffer Ave.
14. FATHER'S NAME First Middle Last John Hutzell			15. MOTHER'S MAIDEN NAME First Middle Last Susan Melinda Cunningham		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 215-09-7389		17. INFORMANT Mrs. Maryada Hutzell	
				Address 109 Stouffer Ave. Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cardiovascular Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours 2 yrs 9 mths 3 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Tracheobronchitis; pulmonary emphysema; diverticulosis-sigmoid.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Oct 2 , 19 68 , to Dec 30 , 19 68 , that (I) (we) last saw the deceased alive on Dec 28 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>W. T. Layman, M.D.</i>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) William T. Layman, M.D.		22e. ADDRESS 301 E. Antietam Street, Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 1 1969		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery	
23d. LOCATION (City or Town) (County) (State) Boonsboro Wash. Md.					
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 3 1969	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

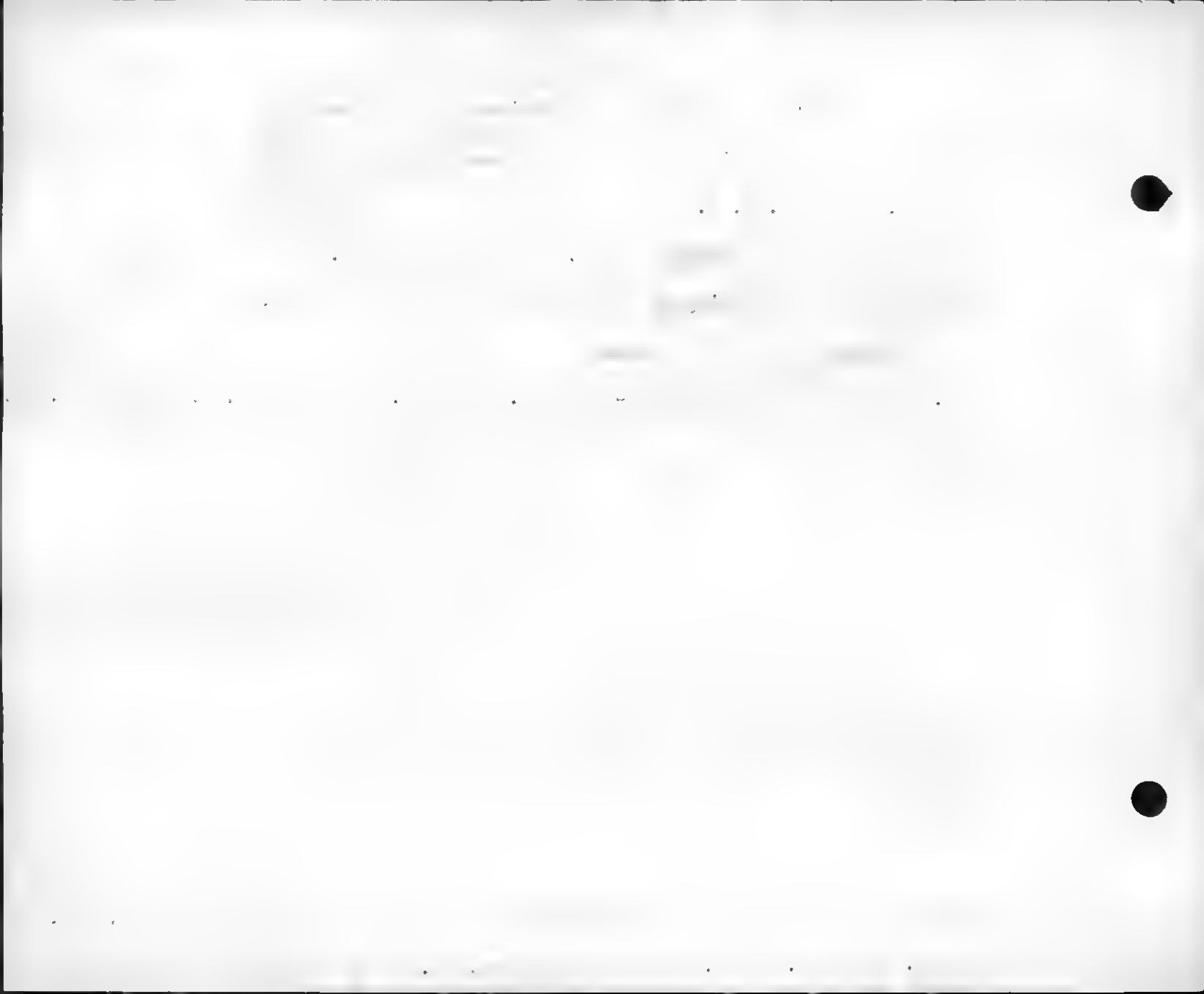
VR-146
304 REV. 68



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and the certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

183874										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										18387									
1 DECEASED-NAME (Type or print)										2a DATE OF DEATH										2b HOUR									
Wanda Arlene Jamison										December 29, 1968										2:00A M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
Female			White			June 19, 1916			52 YRS.			MONTHS			DAYS														
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH																				
Roxberry, Md.			U. S. A.						Washington						Md.														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
Hagerstown			Washington Co. Hospital			Housewife			Own Home																				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER																	
Maryland			Washington			Hagerstown						Rfd. 3																	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																								
George R. Baker					Ida Pearl Long																								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17 INFORMANT Address																			
No.					212-38-9472					Mr. Harvey L. Jamison, Rfd. 3, Hagerstown, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute pulmonary edema																													
4129 DUE TO, OR AS A CONSEQUENCE OF																													
Congestive heart failure																													
DUE TO, OR AS A CONSEQUENCE OF																													
Arteriosclerotic heart disease																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
4200 renal shut down- etiology unknown																													
19a DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
none					-																								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b TIME OF INJURY HOUR A.M. Month Day Year P.M. none 19					21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) none					21f. LOCATION Street or RFD No City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from Aug, 19 61, to Dec, 19 68, that (I) (we) last saw the deceased alive on Dec 29 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b SIGNATURE Harold R. Trisch, Jr MD DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c DATE SIGNED 12/30/68																													
22d PHYSICIAN'S NAME (Type) Harold R. Trisch, Jr MD 22e ADDRESS 302 N. Potomac St Hagerstown, Md																													
23a BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c NAME OF CEMETERY OR CREMATORY					23d LOCATION (City or Town) (County) (State)														
Burial					12- 31- 68					Cedar Lawn Memorial Park					Hagerstown, Wash. Co., Md.														
24 FUNERAL DIRECTOR ADDRESS										25a REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE														
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md										JAN 6 1969					Charles Judge														

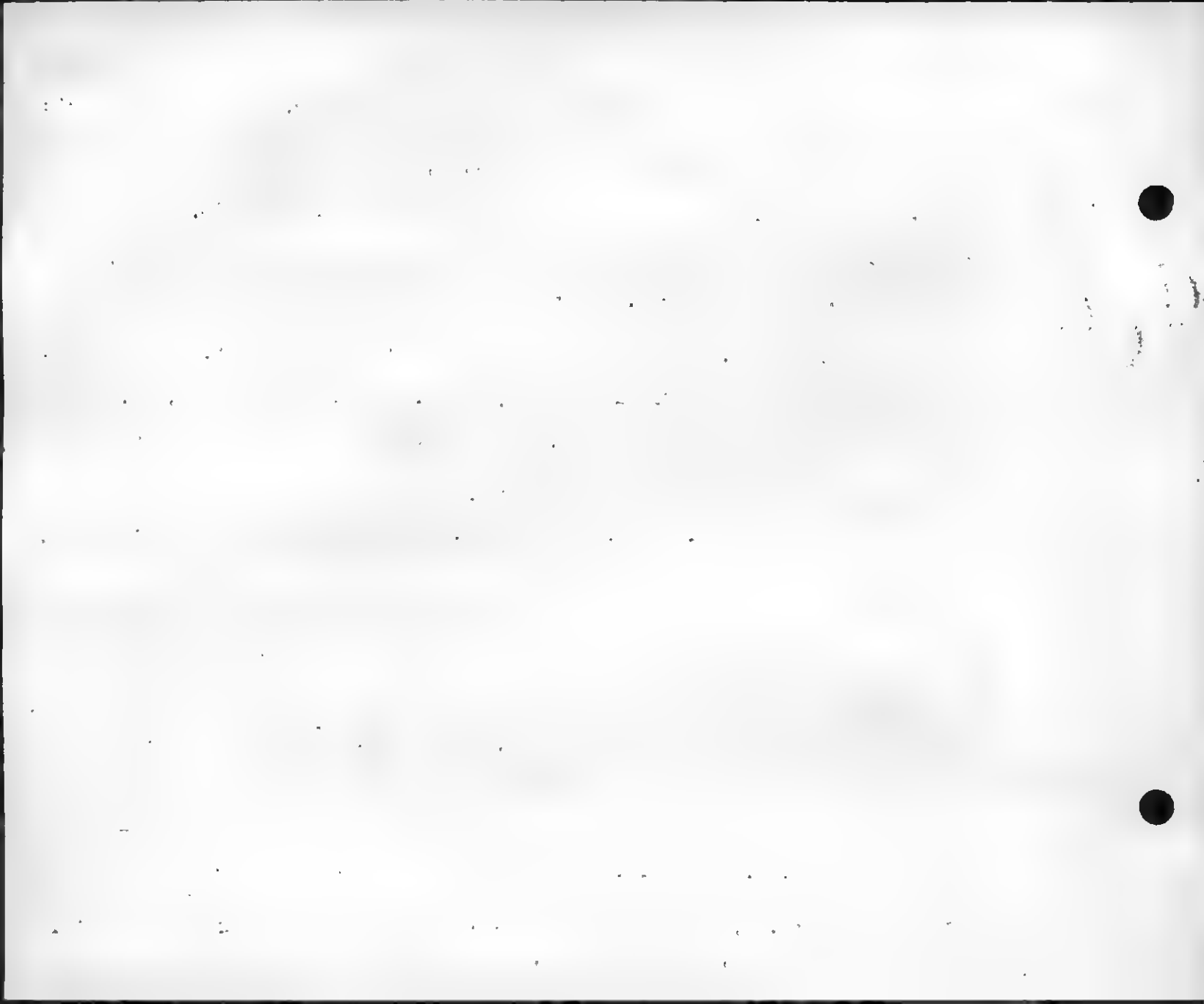


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30A REV

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1 DECEASED-NAME (Type or print)			First Jesse		Middle Joseph		Last Kendall		2a. DATE OF DEATH Dec. Month 3 Day 1968			2b. HOUR 12:10A					
3 SEX Male			4 RACE White			5. DATE OF BIRTH Nov. 2, 1883			6. AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington Co.			Md.					
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Blacksmith			12b. KIND OF BUSINESS OR INDUSTRY Railroad								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Wash.			13c. CITY OR TOWN Smithsburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER RD # 2					
14. FATHER'S NAME			First William		Middle T.		Last Kendall		15. MOTHER'S MAIDEN NAME			First Margaret		Middle S.		Last Brunner	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO. 705-10-4598A			17. INFORMANT Mrs. Eva M. Smith.			Address Chewsville, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest due to ventricular arrhythmia</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH instant					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarctions</u>												2 years					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardiovascular disease</u>												10 years.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town			County		State			
22a. I certify that (I) (this hospital) attended the deceased from 8-14, 19 54, to 12-3, 19 68, that (I) (we) last saw the deceased alive on 12-2, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Charles F. Hess								DEGREE ATTENDING PHYS.			<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12-3-68			
22d. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.								22e. ADDRESS Smithsburg, Maryland 21783									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Dec. 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery			23d. LOCATION (City or Town) Smithsburg Wash.			(County) Md.			(State)			
24. FUNERAL DIRECTOR Minnich Funeral Home, Smithsburg, Md.								25a. RECEIVED BY REGISTRAR DEC 6 1968			25b. REGISTRAR'S SIGNATURE Charles Judge						

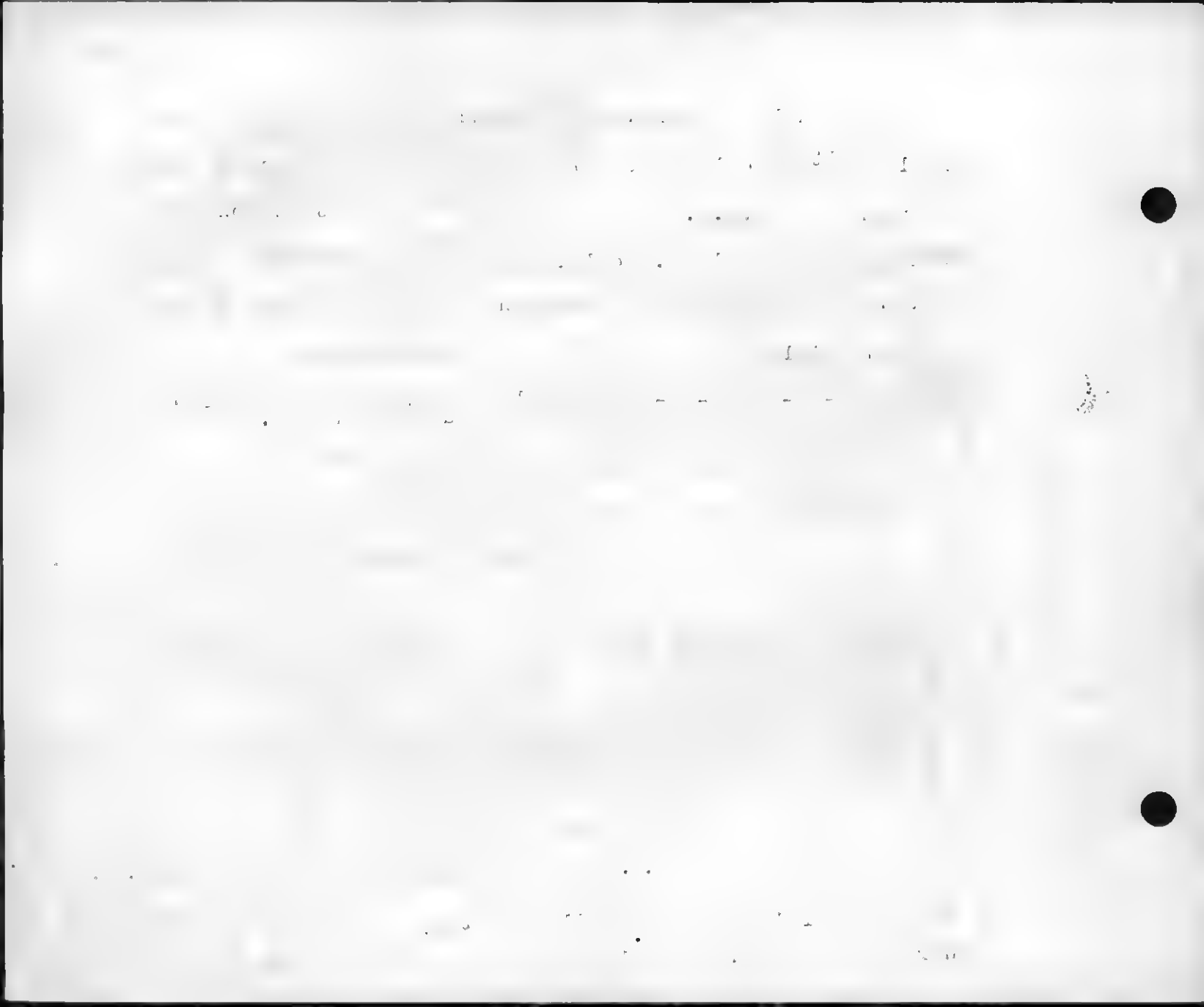


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form WM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED		2b HOUR	
MARY ELIZABETH KLINE						Dec 29 19 68		4:10 PM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 24 HRS MONTHS DAYS HOURS MIN	8 MARRIED NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED	2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR	
Female	White	Dec 12 1901	67 YRS			Dec 29 1968		5:15 PM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		9 COUNTY OF DEATH		12b KIND OF BUSINESS OR INDUSTRY			
Maryland		U.S.A.		Washington		Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Funkstown			10 W. Poplar St			Housewife		Home	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
Maryland			Washington			Funkstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Fred Feigley			Mary Green						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS			
No			214-09-4858			Paul A? Kline 1635 Timberlane Hagerstown Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Pneumonia Secondary to</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>Influenza</u>									
(b) <u>Influenza</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
<u>Large Ventral Hernia</u>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18.)			
CAUSE OF DEATH			19						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			12-30-68			
Edward W. Ditto III, D.			DEPUTY MEDICAL EXAMINER			217 Washington St. Hagerstown Md.			
ADDRESS (Street, city, town, or county)			23a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE			
			JAN 6 1969			Charles Judge			
23a BURIAL CREMATION OR REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)
Burial			1/1/69			Rose Hill Cemetery			Hagerstown Wash Co Md
24. FUNERAL DIRECTOR			Hagerstown Md. ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE
Andrew K. Coffman Funeral Home Inc						JAN 6 1969			Charles Judge

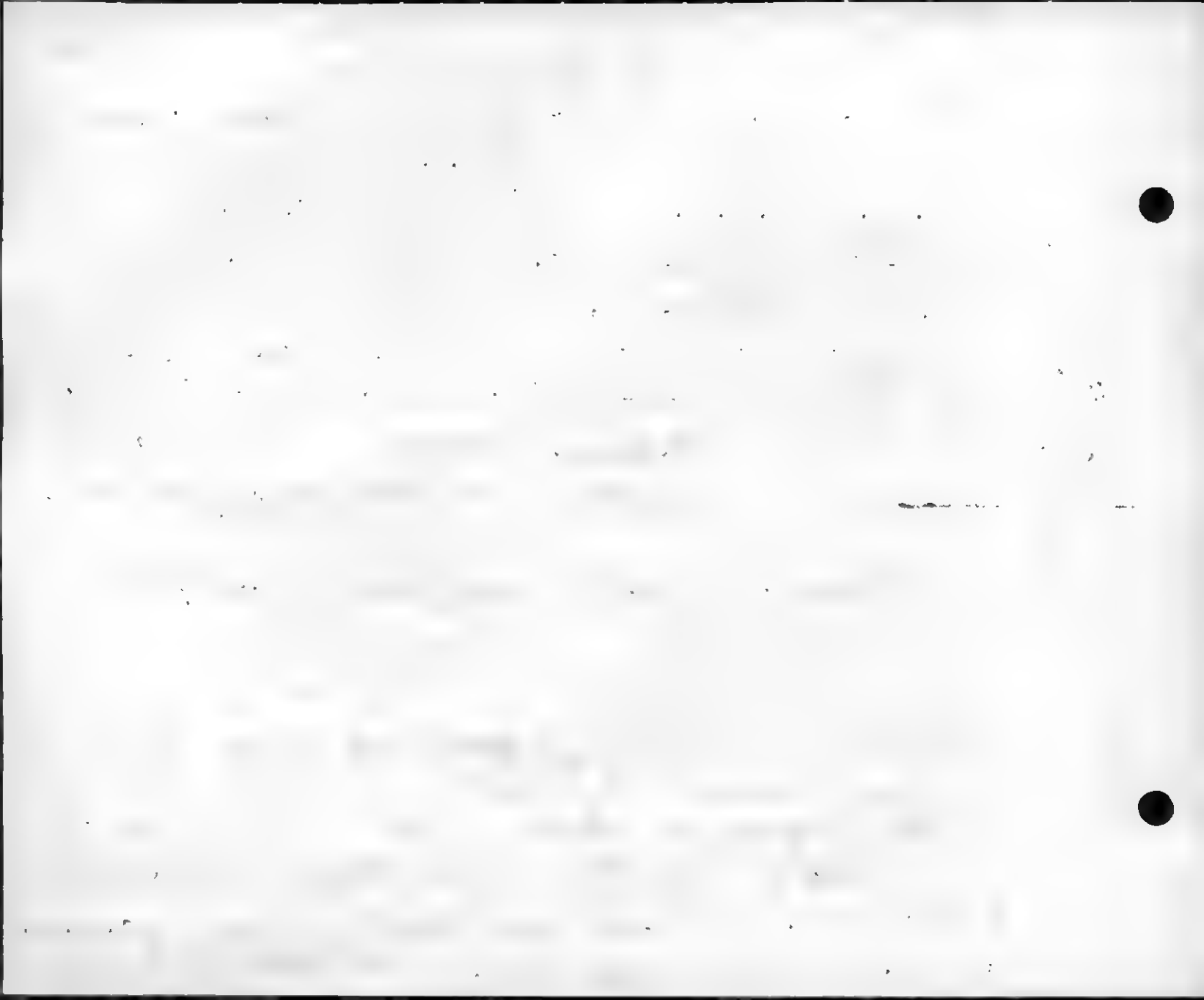


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18390											
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <u>Grady Knapp</u>						2a. DATE OF DEATH <u>December 15 1968</u>			2b. HOUR <u>230 A</u>		
3. SEX <u>male</u>		4. RACE <u>white</u>		5. DATE OF BIRTH <u>Sept. 1, 1904</u>		6. AGE (In years last birthday) <u>64</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Washington</u> Md.					
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington Co. Hospital</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Retired Laborer</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Gen Labor</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Frederick</u>		13c. CITY OR TOWN <u>Nr. Myersville</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>Route # 2</u>			
14. FATHER'S NAME First <u>John Austin</u> Middle <u>Knapp</u> Last <u>Elizabeth</u>				15. MOTHER'S MAIDEN NAME First <u>Rebecca</u> Middle <u>Tyree</u> Last <u>2</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>no</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <u>215-12-2504</u>		17. INFORMANT Address <u>Mrs. Earnie N. Knapp, Myersville, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive and Arteriosclerotic Heart disease</u>											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>443x Chronic bronchitis and pulmonary emphysema</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 3, 1968</u> to <u>Dec 15, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov 14, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Charles C. Spencer M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>12-15-68</u>					
22d. PHYSICIAN'S NAME (Type) <u>Charles C. Spencer</u>						22e. ADDRESS <u>145 S. Prospect St. Hagerstown</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 18, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Salem United Methodist</u>		23d. LOCATION (City or Town) (County) (State) <u>Wolfsville Fred. Co. Md.</u>					
24. FUNERAL DIRECTOR <u>Paul F. Bittle, Myersville, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 19 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A1574)
30A REV. 1/68

18378												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												18391											
1 DECEASED NAME												2a DATE OF DEATH												2b HOUR											
(Type or print)												Month Day Year												P. M.											
MARY FRANCES LESHER												DECEMBER 25 1968												9:30 P.											
3 SEX				4 RACE				5. DATE OF BIRTH				6. AGE (In years last birthday)				IF UNDER 1 YEAR				IF UNDER 24 HRS															
FEMALE				WHITE				9/15/1880				88 YRS.				MONTHS				DAYS															
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH				Md.																			
MARYLAND				U.S.A.								WASHINGTON																							
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY																							
HAGERSTOWN				WASHINGTON CO. HOSPITAL				HOUSEWIFE				HOME																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER																			
MARYLAND				WASHINGTON				HAGERSTOWN				X				1905 GAY ST.																			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																															
JOHN CYRUS MOORE				AMANDA GROVE																															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				Address																							
NO				NONE				MR. FREDERICK C. LESHER				HAGERSTOWN MD.																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY:																																			
IMMEDIATE CAUSE (a) <i>Adenocarcinoma Carcinoma of</i>																																			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sigmoid Colon Ad.</i>																																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>153</i>																3+ yrs.																			
DUE TO, OR AS A CONSEQUENCE OF (c)																																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																			
<i>Arteriosclerotic Cardiac Dis.</i>																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that (I) (this hospital) attended the deceased from <i>12 May 1965</i> , to <i>25 Dec 1968</i> , that (I) (we) last saw the deceased alive on <i>25 Dec 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.																																			
22b. SIGNATURE <i>Richard T. Binford</i> DEGREE <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>																22c. DATE SIGNED 26 Dec. 68																			
22d. PHYSICIAN'S NAME (Type) Richard T. Binford M.D.																22e. ADDRESS 1135 Potomac Ave. - Hagerstown, Md.																			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)																							
BURIAL				12/28/68				REST HAVEN CEM.				HAGERSTOWN WASH. MD.																							
24. FUNERAL DIRECTOR <i>W. J. Harment, Hagerstown, Md.</i> ADDRESS																25a. REC'D BY REGISTRAR DEC 31 1968				25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>															



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VS A15
30M REV 1-68

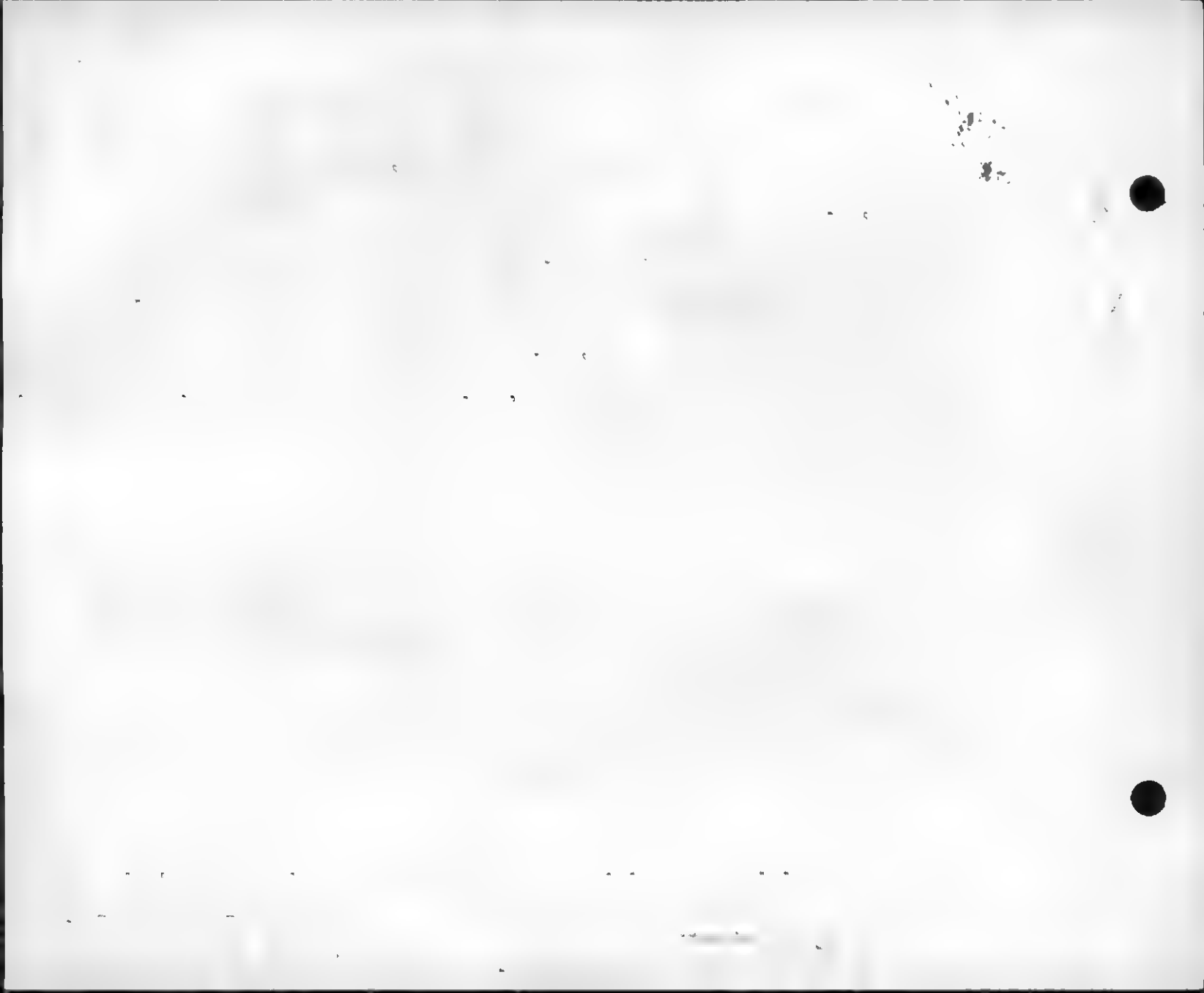
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

18370

18392

1. DECEASED-NAME (Type or print) <div style="display: flex; justify-content: space-between;">First <i>Donna</i>Middle <i>Mae</i>Last <i>Long</i></div>			2a. DATE OF DEATH <div style="display: flex; justify-content: space-between;">Month <i>December</i>Day <i>23</i>Year <i>1968</i></div>			2b. HOUR <i>M</i>					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>August 4, 1939</i>		6. AGE (In years last birthday) <i>29</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>Hagerstown, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i> Md.					
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Co. Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>None</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>481 Mitchell Ave.</i>		
14. FATHER'S NAME <div style="display: flex; justify-content: space-between;">First <i>George</i>Middle <i>C</i>Last <i>Long, Sr.</i></div>			15. MOTHER'S MAIDEN NAME <div style="display: flex; justify-content: space-between;">First <i>Frances</i>Middle <i>Grace</i>Last <i>Turner</i></div>								
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, na, or unknown) <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <i>None</i>		17. INFORMANT Address <i>Mr. Geo. Long 481 Mitchell Ave. Hagerstown, Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral anoxia & Pyrexia</i> <i>410X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>flu</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>1 wk.</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>481X</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>20 Dec 68</i> , 19 <i>68</i> to <i>23 Dec 68</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>23 Dec 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>J. D. Wilson, M.D.</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12/24/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>J.D. Wilson M.D.</i>						22e. ADDRESS <i>580 Northern Ave. Hagerstown, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12/28/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Hagerstown-Washington-Md.</i>					
24. FUNERAL DIRECTOR <i>Wm. G. Host</i> <i>Rest Haven Funeral Chapel Hagerstown, Md.</i>						25a. REC'D BY REGISTRAR DATE <i>DEC 30 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

MEDICAL CERTIFICATE ON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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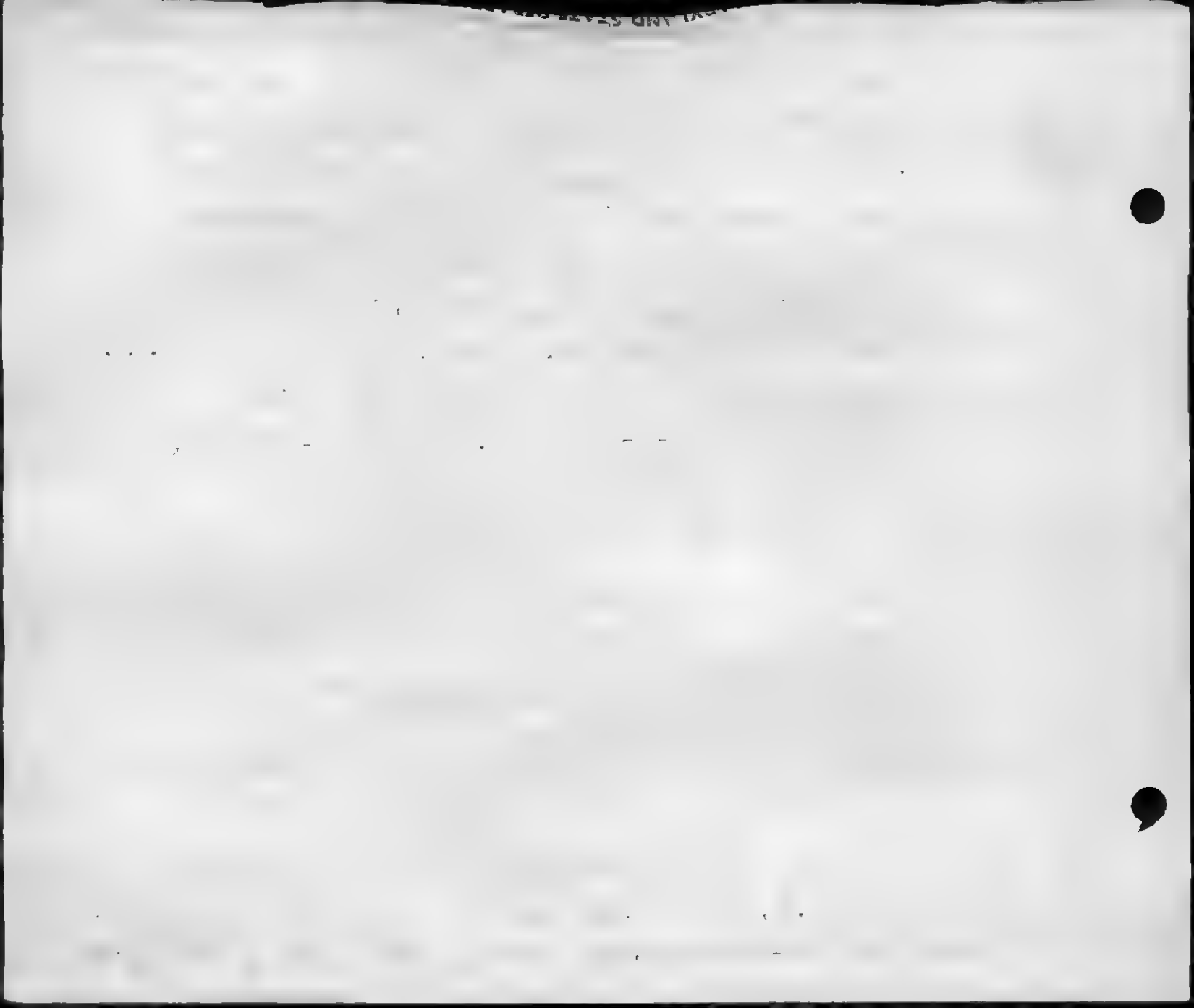
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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

18320

18392

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>621 Maryland Avenue</u>			
3. NAME OF <u>Woodrow</u> <u>Wilson</u> <u>Lynch</u> (Type or print) First Middle Last				4. DATE OF DEATH <u>December</u> <u>24</u> <u>1968</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 21, 1916</u> <u>52</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pangborn Corp.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Homer Blaine Lynch</u>				14. MOTHER'S MAIDEN NAME <u>Dammie Frances Bolder</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				17. INFORMANT <u>Mrs. Mildred Lynch-Hagerstown, Maryland</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>hypertension</u> DUE TO (c) <u>arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hypertension</u> <u>arteriosclerosis</u> <u>heart</u> <u>diabetes</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-23</u> 19 <u>68</u> to <u>12-24</u> 19 <u>68</u> that (I) (we) last saw the deceased alive on <u>12-24</u> 19 <u>68</u> and that death occurred at <u>9:00</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>12-26-68</u>			
22c. PHYSICIAN'S NAME (Type) <u>E. J. Lindig, M.D.</u>				22d. ADDRESS <u>300 N. Adams St. Martinsburg, West Virginia</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 27, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rosedale Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Martinsburg West Virginia</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Brown</u> ADDRESS <u>Brown Funeral Home-Martinsburg, West Virginia</u>				25a. REC'D BY REGISTRAR <u>DEC 30 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

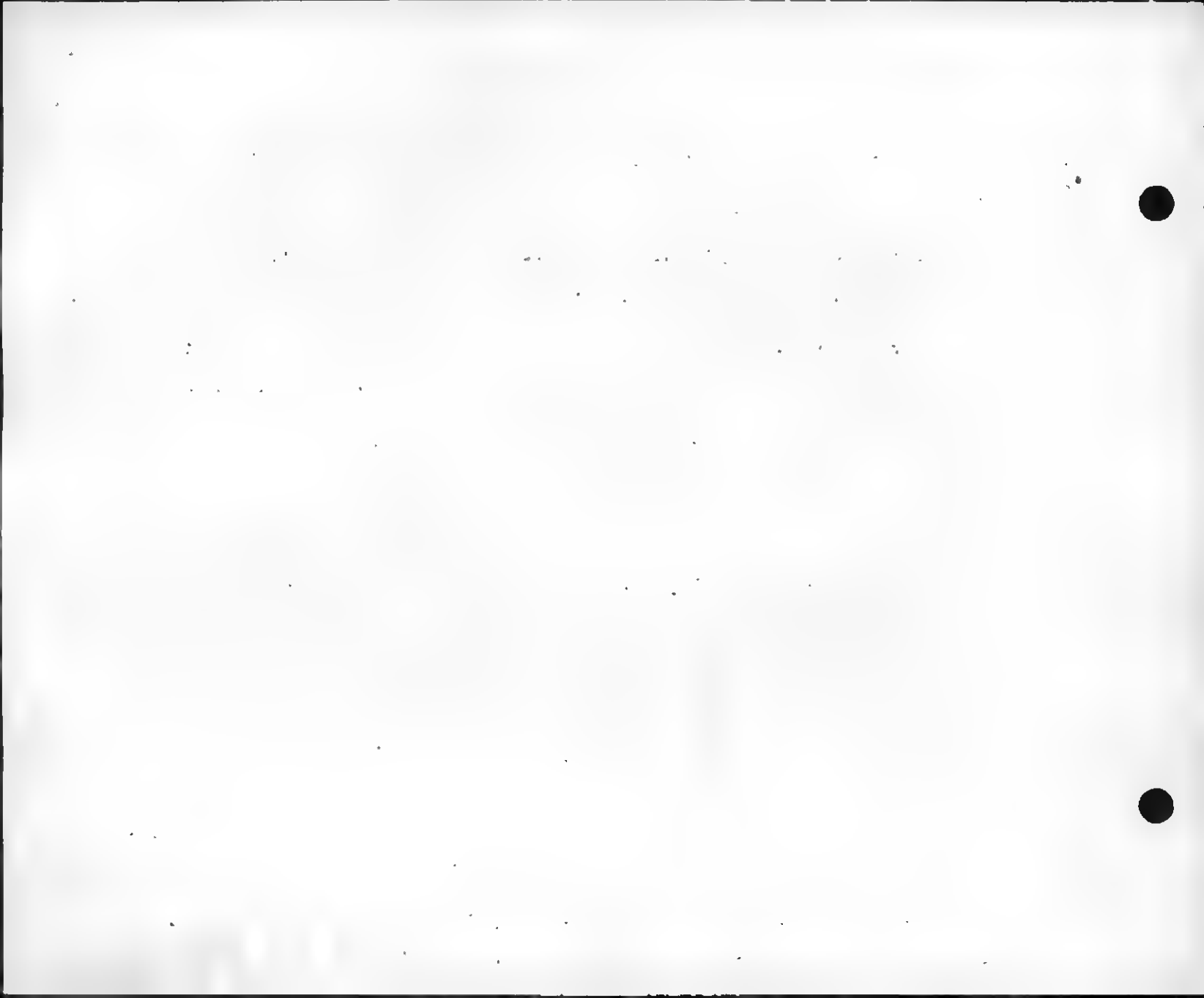
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18381

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18394

1. DECEASED-NAME (Type or print) Lucia		First		Middle		Last		2a. DATE OF DEATH Month December Day 22 , Year 1968		2b. HOUR 8:30 A M	
3. SEX female		4. RACE white		5. DATE OF BIRTH 12-13-1892		6. AGE (in years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN _____	
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 55 E. Franklin, St.				12a. US. OCCUPATION (Kind of work done during most of work ng life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 55 E. Franklin, St.			
14. FATHER'S NAME First Pietro D. Adamo Middle _____ Last _____				15. MOTHER'S MAIDEN NAME First Rosaria Middle LaVergetta Last _____							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Pietro Mancini Hagerstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 17c. RETROPERITONEAL SARCOMA IMMEDIATE CAUSE (a) RETROPERITONEAL SARCOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 158x (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14-15mo	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) RETROPERITONEAL C.V. DISEASE - DISTENTED VESICLES											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____							
22a. I certify that (I) (this hospital) attended the deceased from 14 Feb , 19 63 , to 22 Dec , 19 68 , that (I) (we) last saw the deceased alive on 16 Dec , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]		22c. DATE SIGNED 23 Dec. 1968		22d. PHYSICIAN'S NAME (Type) Wm Noel Fendoe		22e. ADDRESS 218 N. Potomac St. Hagerstown, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 12-27-68		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.					
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 27 1968		25b. REGISTRAR'S SIGNATURE [Signature]					

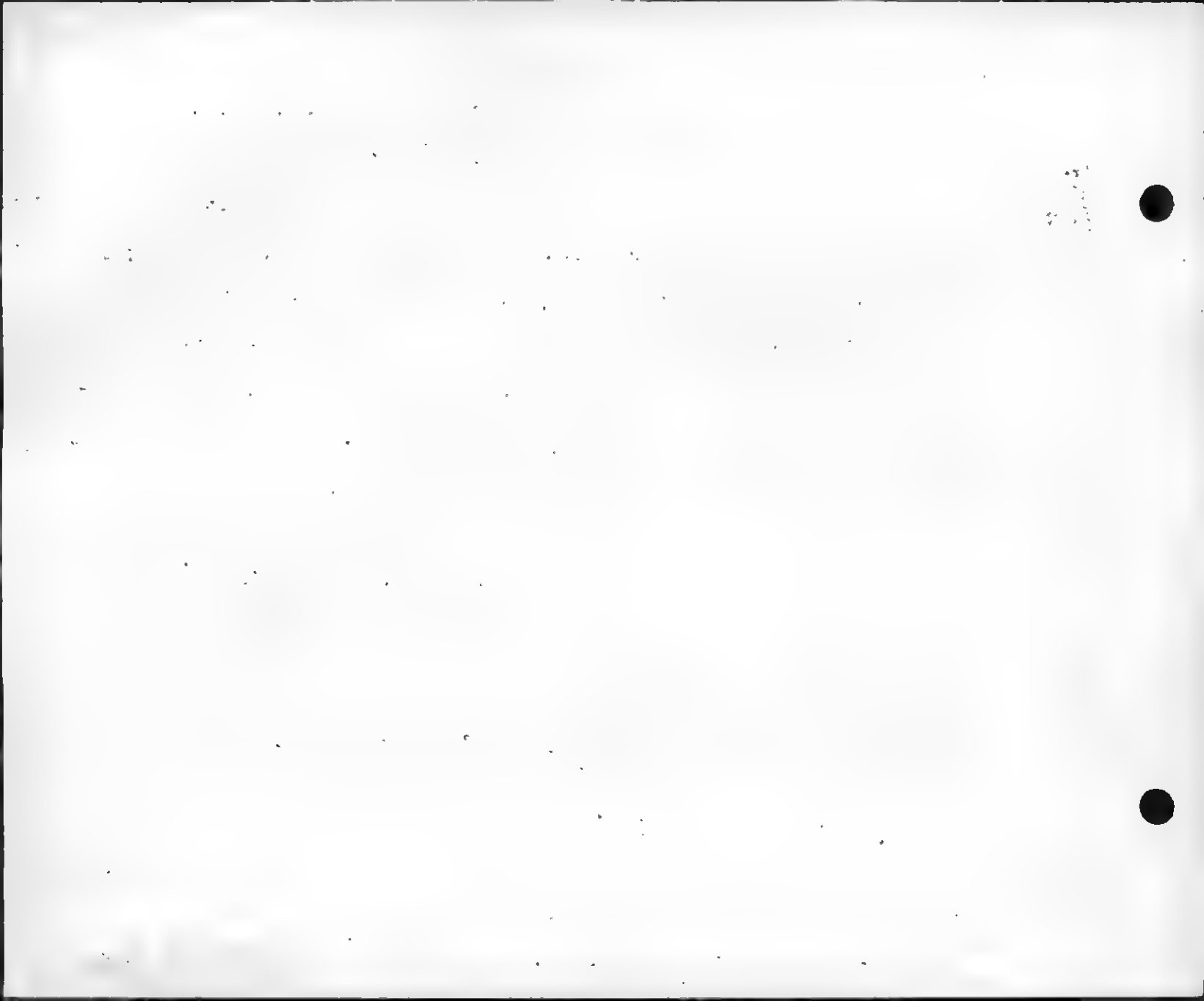


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A16 (4)
30M REV. 1-7-68

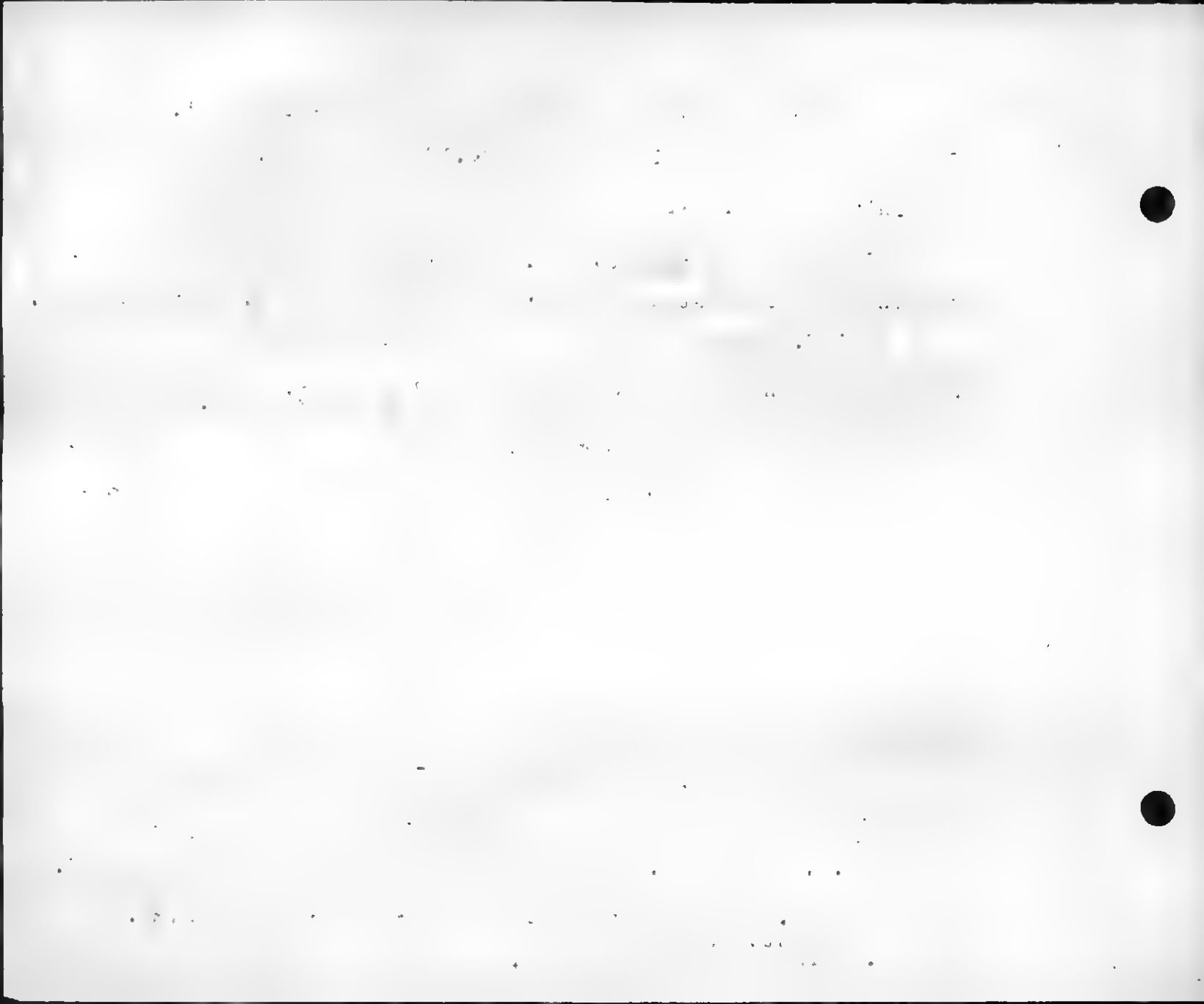
MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) Ethel Louise Miller						2a. DATE OF DEATH Dec. 22, 1968 Year			2b. HOUR M			
3. SEX female		4. RACE white		5. DATE OF BIRTH Aug. 6, 1888			6. AGE (In years last birthday) 80 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS M.N.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.						
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Jackson Con. Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Hair Dresser			12b. KIND OF BUSINESS OR INDUSTRY Self Employed			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 1006 Potomac Ave.			
14. FATHER'S NAME First Perry W. Middle Miller Last				15. MOTHER'S MAIDEN NAME First Minnie Middle Valentine Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17. INFORMANT Address Dr. Althea Miller, Hagerstown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic Cardio Dis. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4/2/21										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebral thrombosis & right hemiparesis (3 yrs) atrial fibrillation												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 200 1965 to date 19 , that (I) (we) last saw the deceased alive on 2 days 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Richard T. Binford						22c. DATE SIGNED 23 Dec. 1968		22d. ADDRESS 1135 Potomac Ave., Hagerstown, Md. 21740				
23a. BURIAL, CREMATION, or other disposition burial		23b. DATE 12-26-68		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.						
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.						25a. REC'D BY REGISTRAR DATE DEC 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and return them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR M			
URSULA MAY MILLER						December 11, 1968						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		Aug. 12, 1896			72 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Virginia		U.S.A.				Washington Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown			Washington Co. Hospital			House Wife			Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER					
Maryland Washington			Hagerstown				308 S. Cleveland Ave.					
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last								
Carl F. Harper				Frances Lambert								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
None				None		Earl Miller 308 S. Cleveland Ave Hagerstown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>										Minutes		
4369 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u>										Years		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
331X												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>J.D. Wilson</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>12/2/68</u>				
22d. PHYSICIAN'S NAME (Type) J.D. Wilson Md.						22e. ADDRESS 580 Northrn Ave Hagerstown, Md.						
23a. BURIAL, CREMATION, <u>BURIAL</u>		23b. DATE Dec. 4, 1968		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) Hagerstown, Md.		(County)		(State)		
24. FUNERAL DIRECTOR Hagerstown, Md. Andrew K. Coffman Funeral Home Inc.						25a. REC'D BY REGISTRAR DEC 3 1968		25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>				

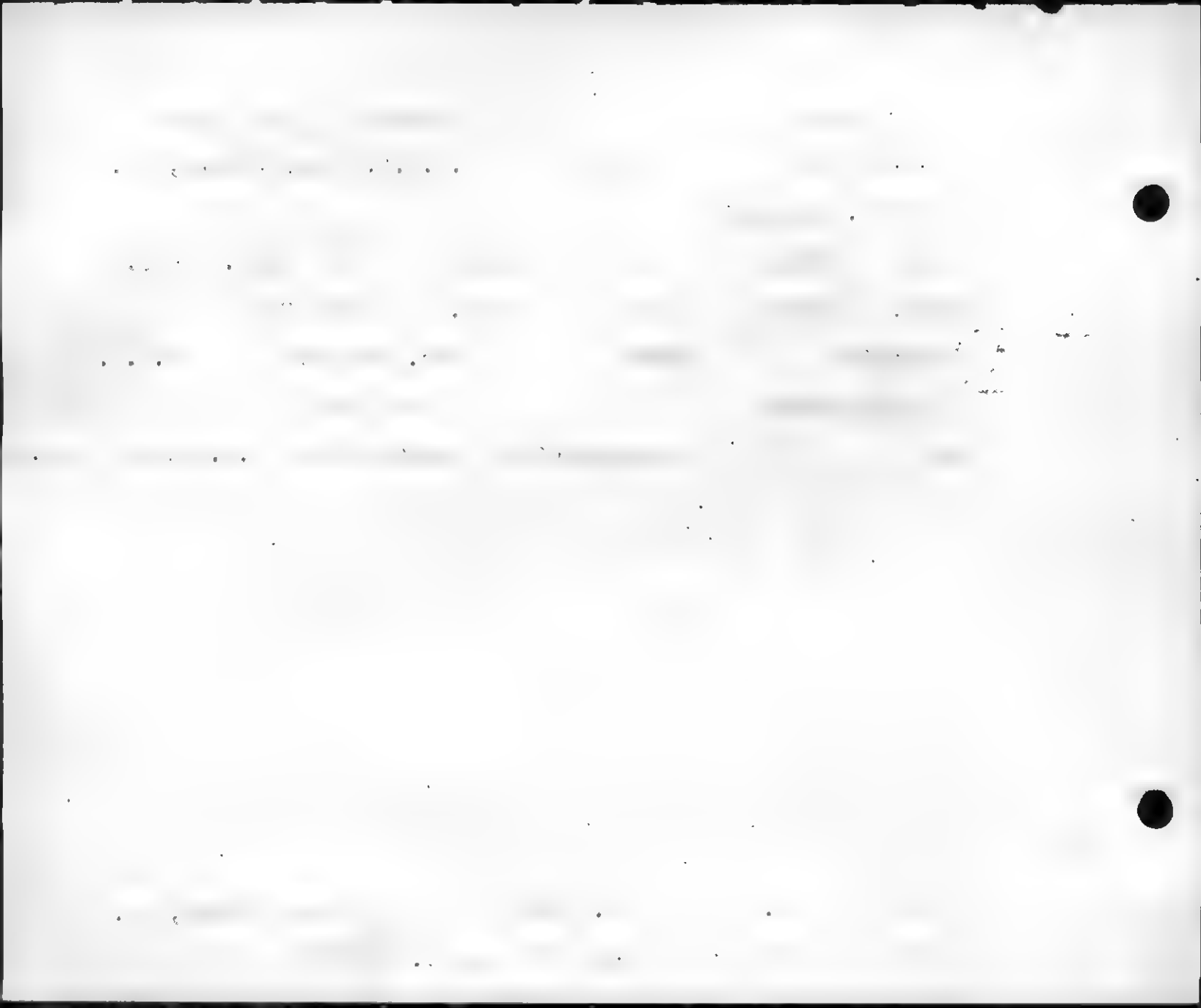


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
18384
CERTIFICATE OF DEATH

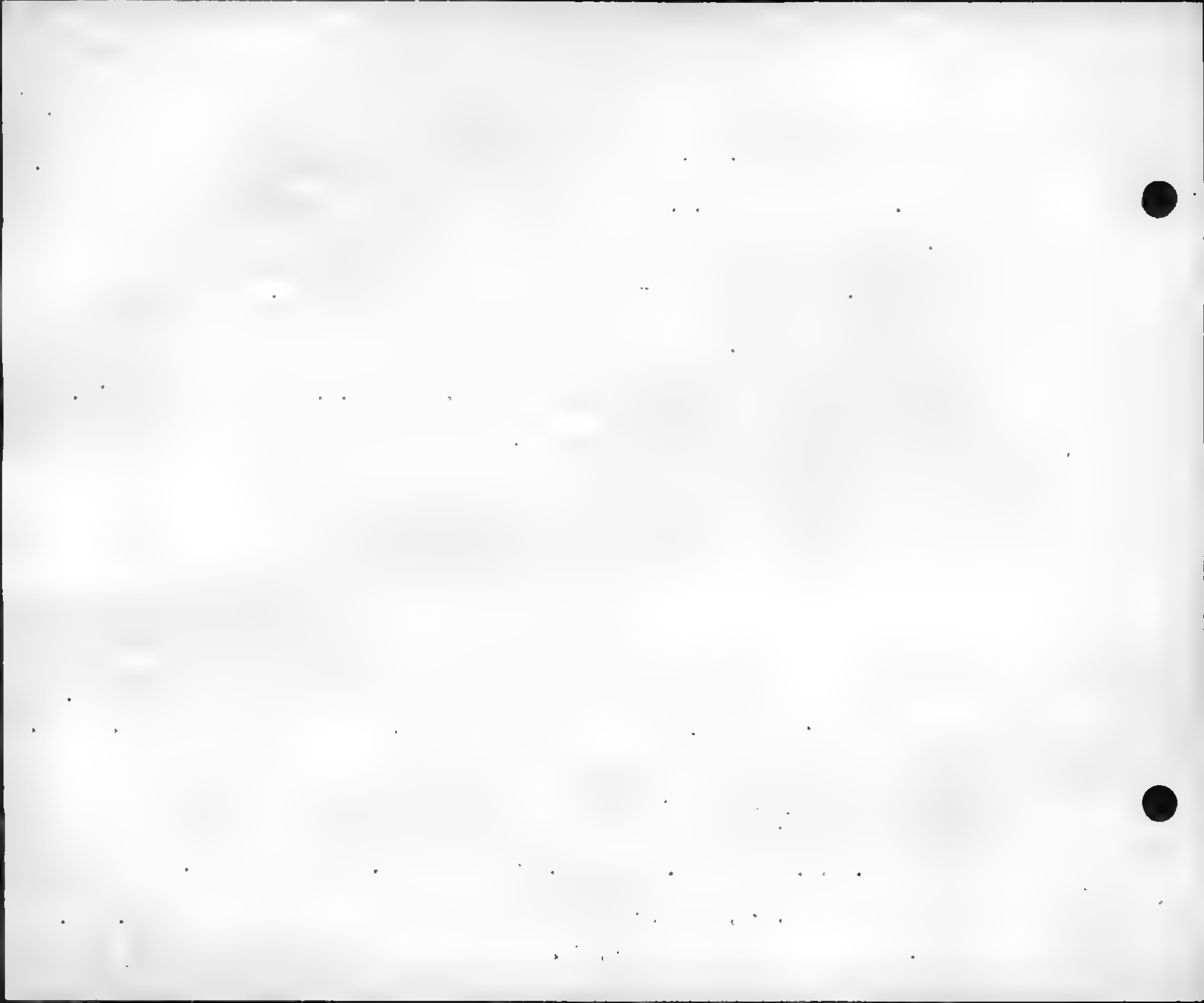
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN ID 1 Week d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash Co. Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D.2, Clear Spring, Md. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lela May Mills		4. DATE OF DEATH Month Dec. Day 16th. Year 1968	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1889
9. AGE (in years last birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Wash. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alvin Myers		14. MOTHER'S MAIDEN NAME Emma Myers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-34-4030A	
17. INFORMANT Raymond Mills		Address R.D.2, Clear Spring	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medical 402X DUE TO (b) hypertensive heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 11			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 44-X			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on Dec 14 1968 , and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE Francis Roselle		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) FRANCIS ROSELLE		22d. ADDRESS 386 Northern Ave. Clear Spring	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 19, 68	
23c. NAME OF CEMETERY OR CREMATORY St. Paul		23d. LOCATION (City, town or county) (State) Clear Spring, Md	
24. FUNERAL DIRECTOR Donald E. Thompson		25a. REC'D BY REGISTRAR DEC 23 1968	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. REGISTRAR'S NAME Thompson Funeral Home Clear Spring, Md	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. (Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1003. Page 5 may be retained for your files.)
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

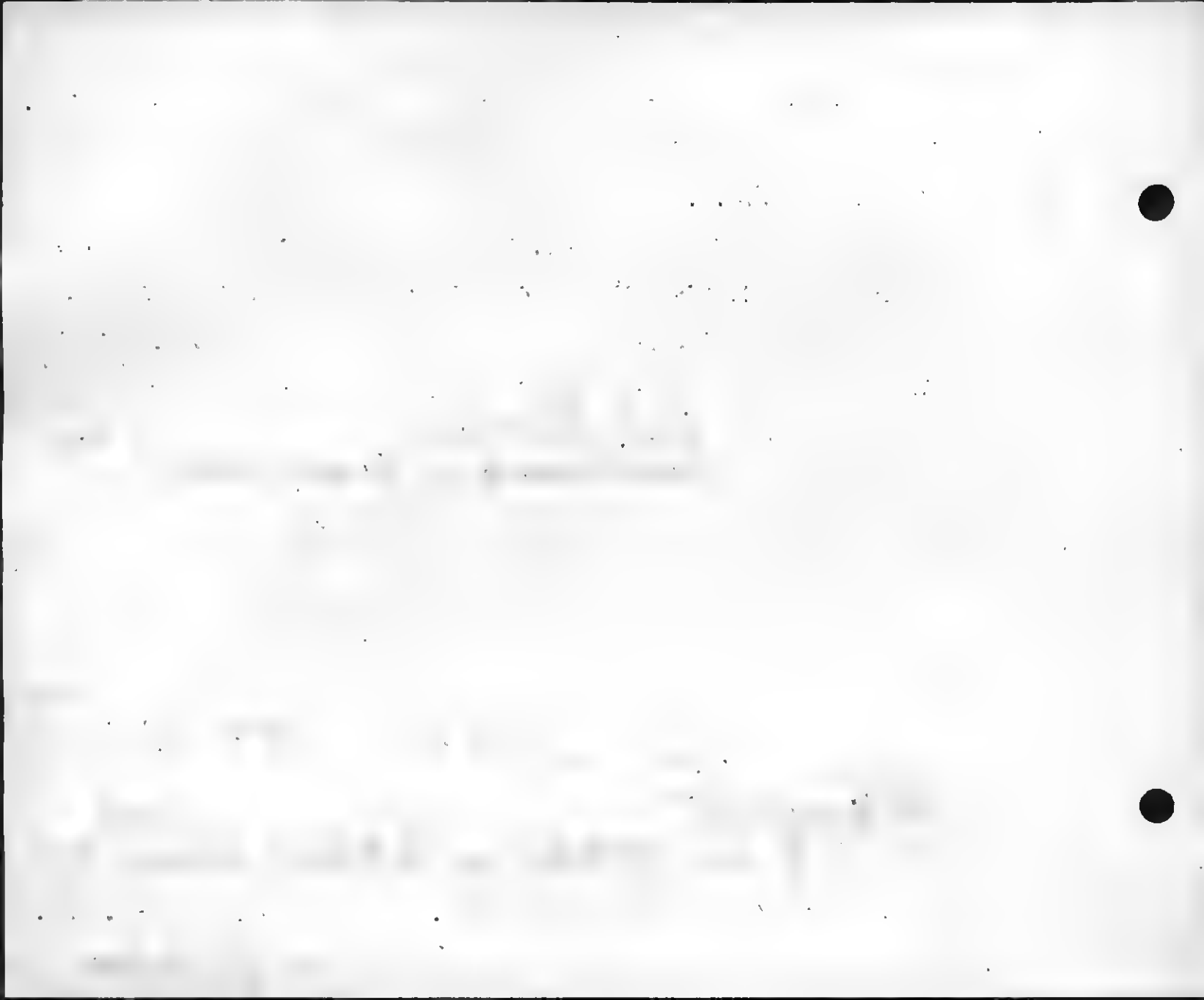
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or Print)			First Terry			Middle Lee			Last Mong			
3 SEX Male		4 RACE White		5 DATE OF BIRTH Oct. 24, 1949		6 AGE (In years last birthday) 19 YRS		7 UNDER 24 HRS MONTHS DAYS HOURS MIN		2a DATE KNOWN OF ESTI-DEATH MATED 12-22-68 19		
7a BIRTHPLACE (State or foreign country) Pa.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Washington		2c DATE PRONOUNCED DEAD 12-22-1968		2b HOUR 8:30 A.M.		
10 CITY OR TOWN OF DEATH Hagerstown			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Ridenour Road Route #5			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Helper			12b KIND OF BUSINESS OR INDUSTRY Plummer			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b COUNTY Washington			13c CITY OR TOWN Smithsburg			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER R.D. # 3	
14. FATHER'S NAME First Middle Last Joseph A. Mong			15. MOTHER'S MAIDEN NAME First Middle Last Anna Mae Brown			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			
17. INFORMANT Joseph A. Mong, R.D. # 3, Smithsburg, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) 782X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Possibly 2 hours			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 7:30 12-22-1968 Leaky muffler on standing car with motor			
21b INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21c PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Public Road			21d HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Leaky muffler on standing car with motor			21e LOCATION Street or R.F.D. No City or Town Ridenour Road, Route 5, Hagerstown, Wash. Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>												
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. E.W. Ditto, Jr.			23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE Dec. 26, 1968			23c NAME OF CEMETERY OR CREMATORY Mountain View Cemetery			
23d LOCATION (City or Town) (County) (State) Ringgold Wash. Md.			23e REC'D BY REGISTRAR DATE DEC 30 1968			23f REGISTRAR'S SIGNATURE Charles Judge			23g ADDRESS Minnich Funeral Home, Smithsburg, Md.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First KITTY		Middle MARIE		Last MULLENIX		2a DATE OF DEATH DECEMBER 30 Day 1968		2b HOUR 7 a.m.	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 8/5/1895		6 AGE (In years) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON					
10 CITY OR TOWN OF DEATH HAGERSTOWN		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give place of death) WASHINGTON CO. HOSPITAL		12a USUAL OCCUPATION (Kind of work done during major part of time if retired.) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY HOME					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) MARYLAND		13b WASHINGTON		13c CITY OR TOWN HAGERSTOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 605 W. FRANKLIN ST.			
14. FATHER'S NAME First CLINTON		Middle TROWINGER		Last SUSAN		15 MOTHER'S MAIDEN NAME First STOCKS LAGER		Middle HAGERSTOWN		Last MD.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b SOCIAL SECURITY NO. NONE		17. INFORMANT MR. LEWIS H. MULLENIX							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Atherosclerosis, Primary Heart.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1-4 X</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No.		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from <u>12-29-68</u> , 19 <u>68</u> , to <u>DEC 30 1968</u> , that (I) (we) last saw the deceased alive on <u>12-29-68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (and) view the body after death.											
22b SIGNATURE <u>E. P. Landig</u>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <u>12-30-68</u>					
22d PHYSICIAN'S NAME (Type) E. P. Landig		22e ADDRESS 300 G. B. K. H. Hagerstown Md.									
23a BURIAL, CREMATION, OR OTHER DISPOSITION BURIAL		23b DATE 1/1/69		23c NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d LOCATION (City or Town) HAGERSTOWN		(County) WASH.		(State) MD.	
24 FUNERAL DIRECTOR <u>W. J. Norment</u>		ADDRESS Hagerstown, Md.		25a REC'D BY REGISTRAR DATE JAN 3 1969		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



FOR STATE HEALTH DEPT.

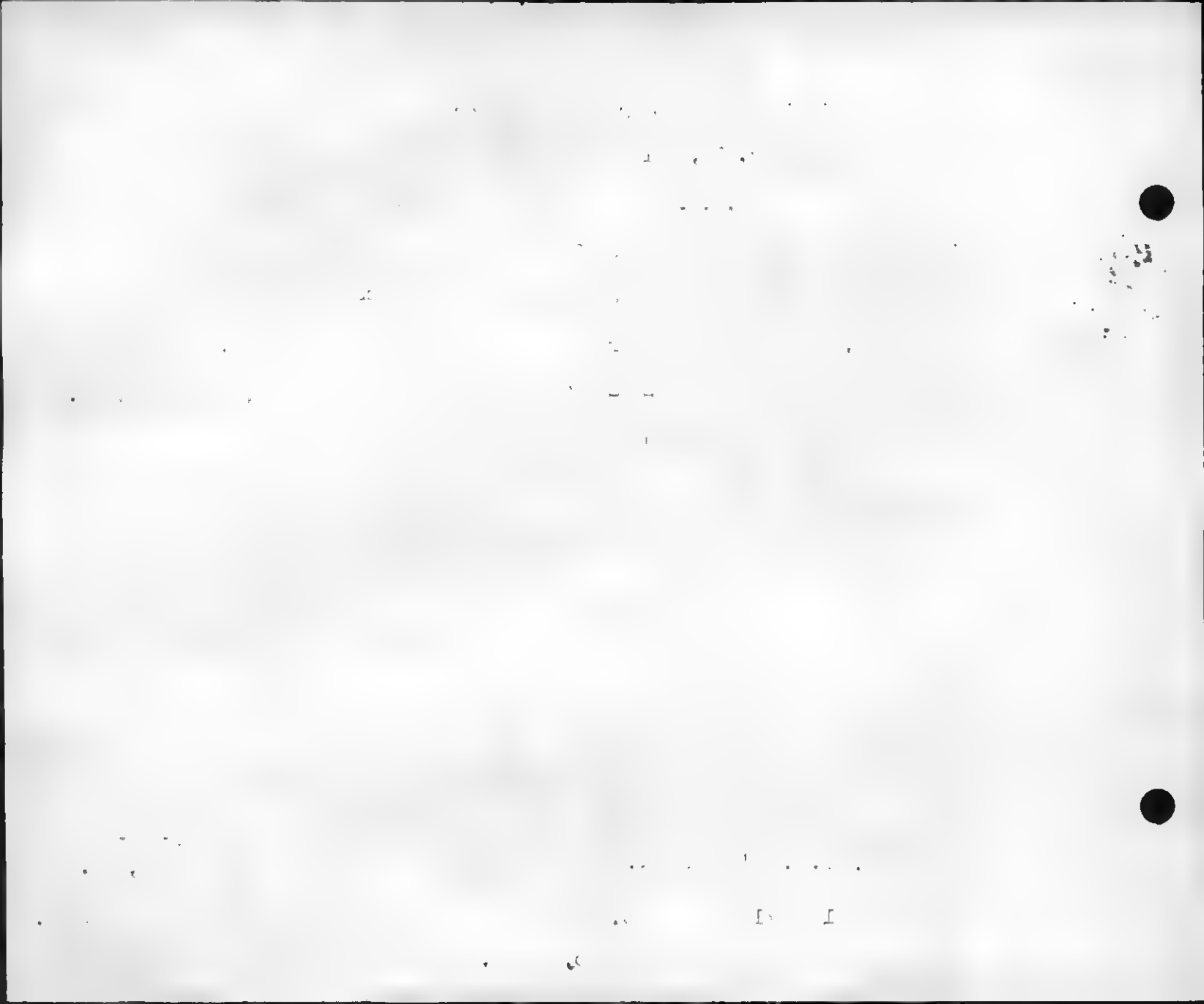
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Film 409 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18400

1 DECEASED NAME (Type or Print)			First William			Middle Howard			Last Naylor			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 12 DAY 26 YEAR 1968			2b. HOUR 10A M		
3 SEX Male		4 RACE White		5 DATE OF BIRTH Aug. 18, 1910		6 AGE (In years last birthday) 58 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month 12 Day 26 Year 1968			2d. HOUR 1230 P		
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. COUNTY OF DEATH Washington Md.					
10. CITY OR TOWN OF DEATH Highfield				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box 3				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Labor				12b. KIND OF BUSINESS OR INDUSTRY Plumbing					
13a. USLA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland				13b. COUNTY Washington				13c. CITY OR TOWN Highfield				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 3			
14. FATHER'S NAME First W. Middle Reuben Last Naylor				15. MOTHER'S MAIDEN NAME First Maude Middle V. Last Cline													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b. SOCIAL SECURITY NO (If yes give year or dates of service) 218-07-2667				17. INFORMANT ADDRESS Miss Helen Naylor Box 3, Highfield, Md.									
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PENDING Thrombotic occlusion of circumflex DUE TO, OR AS A CONSEQUENCE OF branch of left coronary artery (b) Coronary atherosclerosis, moderately advanced DUE TO, OR AS A CONSEQUENCE OF Thrombotic occlusion of right (c) coronary artery, recent Approximate interval between onset and death Several min 5 yrs. Recent																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4301																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE DR. E.W. DITTO, JR.				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 12-26-68					
EXAMINER'S NAME (Type) DR. E.W. DITTO, JR.								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town or county) Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 12/28/1968				23c. NAME OF CEMETERY OR CREMATORY St. John				23d. LOCATION (City or Town) (County) (State) Sabillasville, Frederick, Md.					
24. FUNERAL DIRECTOR David Y. Guare				ADDRESS Waynesboro, Penna.				25a. REC'D BY REGISTRAR DATE DEC 30 1968				25b. REGISTRAR'S SIGNATURE J. Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

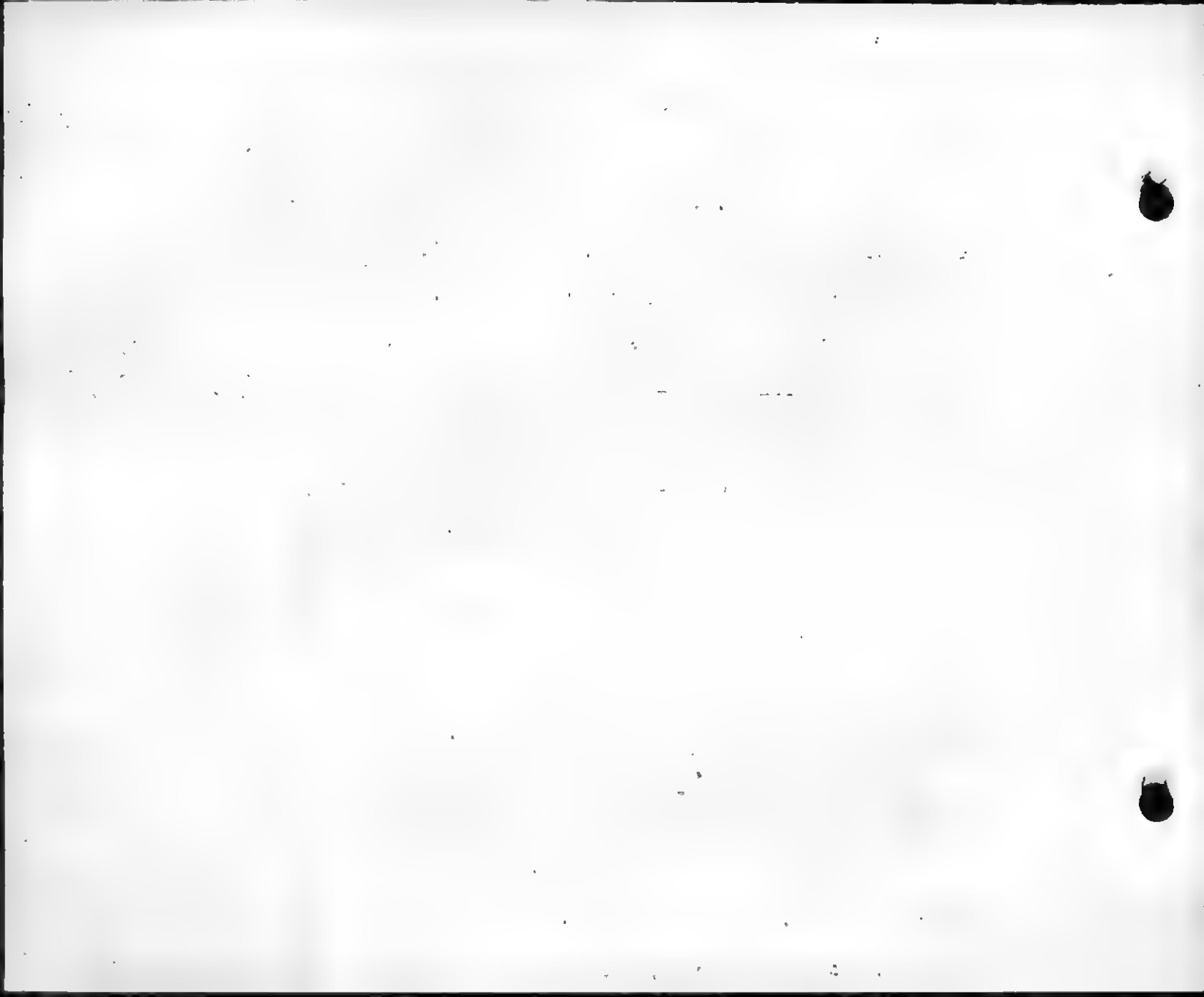
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

18388

18401

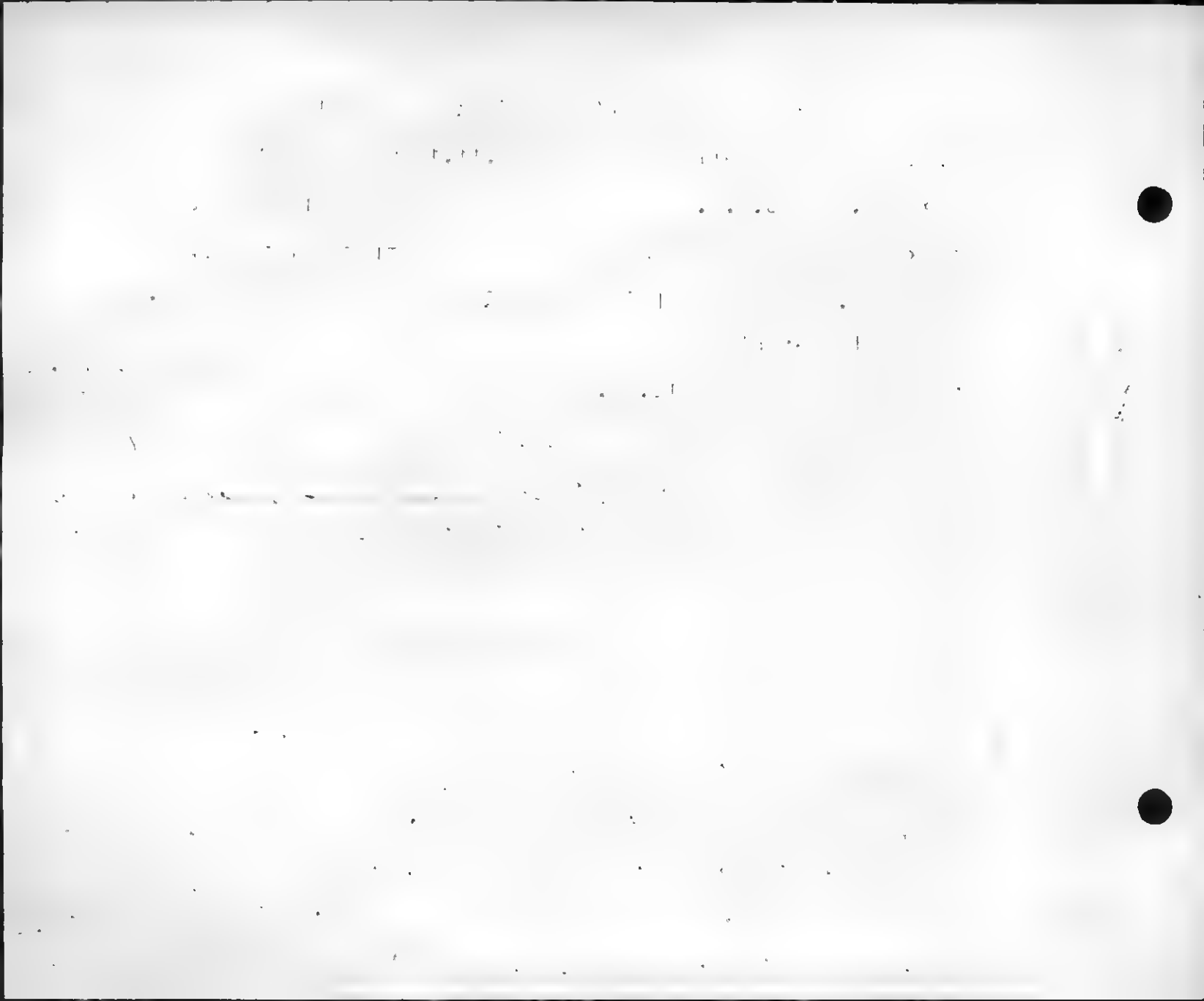
1. DECEASED-NAME (Type or print) First Esther Middle Stewart Last Newcomer			2a. DATE OF DEATH Month Dec. Day 7 Year 1968		2b. HOUR 4:45 PM
3 SEX Female	4 RACE White	5. DATE OF BIRTH March 26 1908		6 AGE (In years last birthday) 60 YRS.	IF UNDER 1 YEAR Months 8 Days 10
7a. BIRTHPLACE (State or foreign country) Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington Md.		
10. CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 15 W. Salisbury St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Williamsport	13d. INSIDE CITY Y/N? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 15 W. Salisbury St.
14. FATHER'S NAME First Barclay Middle Stewart Last Stewart			15. MOTHER'S MAIDEN NAME First Leila Middle Campbell Last Campbell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 220-16-3836		17. PLACE OF DEATH 15 W. Salisbury St. Williamsport Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 4:00 DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial infarction due to coronary artery occlusion DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cardiovascular disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 12 hours 7 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (the doctor) attended the deceased from 05/06/61 , 19__, to 12/07/68 , 19__, that (I) (we) last saw the deceased alive on 12/07/68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) viewed the body after death.					
22b. SIGNATURE <i>Archie Robert Cohen M.D.</i> DEGREE M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 12/09/68	
22d. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.				22e. ADDRESS Clear Spring, Maryland 21722	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 10-68		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	
23d. LOCATION (City or Town) Williamsport Wash. Md.		(County)		(State)	
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Md.				25a. REC'D BY REGISTRAR DATE DEC 13 1968	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
CERTIFICATE OF DEATH																							
18402																							
1. DECEASED-NAME (Type or print)				First LEE				Middle ROY				Last PITTMAN				2a. DATE OF DEATH 12 Month 7 Day 68				2b. HOUR M			
3. SEX MALE				4. RACE WHITE				5. DATE OF BIRTH 4.11.1890				6. AGE (In years last birthday) 78 YRS				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) PENNA.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH WASHINGTON MD.				Md							
10. CITY OR TOWN OF DEATH HANCOCK				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOME				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED STATE RD.				12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD.				13b. COUNTY WASHINGTON				13c. CITY OR TOWN HANCOCK				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 107 FULTON ST.							
14. FATHER'S NAME First Middle Last WILLIAM PITTMAN				15. MOTHER'S MAIDEN NAME First Middle Last SARAH E HESS																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 212.10.8500				17. INFORMANT Address HANCOCK MD.				DELLA B PITTMAN 107 FULTON ST.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u> 2509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 260x												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 min 10 yrs 18 yrs											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from 7/12/60, 19, to 11/18, 1968, that (I) (we) lost saw the deceased alive on 11/18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE FB Thomas III M.D.												DEGREE M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 12/9/68			
22d. PHYSICIAN'S NAME (Type) FB Thomas III M.D.												22e. ADDRESS HANCOCK, Md.											
23a. BURIAL, CREMATION, REINTERMENT				23b. DATE 12.10.68				23c. NAME OF CEMETERY OR CREMATORY DEMASCUS				23d. LOCATION (City or Town) (County) (State) RURAL FULTON COUNTY PENNA											
24. FUNERAL DIRECTOR Address Howard J. Snow Hancock Md.												25a. REC'D BY REGISTRAR DATE DEC 12 1968				25b. REGISTRAR'S SIGNATURE Charles Judge							



FOR STATE
HEALTH DEPT.

TO CERTIFY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18390
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18403

1 DECEASED-NAME (Type or Print) OLEN First ALBERT Middle POOLE Last			2a DATE KNOWN OF EST. DEATH <input checked="" type="checkbox"/> Mated <input type="checkbox"/> 12/21/1968 8:AM			2b HOUR			
3. SEX MALE	4 RACE WHITE	5 DATE OF BIRTH 2/9/1901	6 AGE (in years last birthday) 67 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	7c DATE PRONOUNCED DEAD 12 Month 21 Day 19 68 Year NOON	2d HOUR		
7a. BIRTHPLACE (State or foreign country) N. CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH WASHINGTON Md			
10 CITY OR TOWN OF DEATH HAGERSTOWN			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 92 W. WASHINGTON ST			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CARPENTER		12b KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MARYLAND			13b. COUNTY WASHINGTON		13c CITY OR TOWN HAGERSTOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 92 W. WASHINGTON		
14. FATHER'S NAME First J. Middle HEMING Last POOLE			15. MOTHER'S MAIDEN NAME First LAURA Middle CARICO Last						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b SOCIAL SECURITY NO. 216-16-9259		17. INFORMANT MARY SHIPLEY ADDRESS RFD#1 Box 377 ABERDEEN MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY ATHEROSCLEROSIS WITH OCCLUSION OF ANTERIOR DESCENDING PERICARDITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. LOBULAR PNEUMONIA, EARLY (b) (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT	
19a. DATE OF OPERATION 4/20/1			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE N. E. W. DITTO, JR. EXAMINER'S NAME (Type) DR. E. W. DITTO, JR.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/21/68			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 12/23/68		23c NAME OF CEMETERY OR CREMATORY CAK GROVE CHURCH CEMETERY		23d LOCATION (City or Town) BELAIR (County) Md. (State)			
24 FUNERAL DIRECTOR FOSTER FUNERAL HOME ADDRESS BELAIR MARYLAND				25a REC'D BY REGISTRAR DEC 30 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge			

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FOR STATE
HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) Edward Harry Queen			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Dec Day 25 Year 1968 2b. HOUR 4:30 P								
3. SEX Male	4. RACE Colored	5. DATE OF BIRTH 2-17-1397	6. AGE (in years last birthday) 71 YRS.	7. UNDER YEAR MONTHS 12	8. UNDER 24 HRS HOURS 25	9. COUNTY OF DEATH Washington	10. DATE PRONOUNCED DEAD Month 12 Day 25 Year 1968 2d. HOUR 4:30 P				
7a. BIRTHPLACE (State or foreign country) New York, N.Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington					
10. CITY OR TOWN OF DEATH Hagerstown Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 621 Pennsylvania Ave			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Railroad					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown					
14. FATHER'S NAME Unknown			15. MOTHER'S MAIDEN NAME Unknown			16. SOCIAL SECURITY NO. 214-16-0310					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. 214-16-0310			17. INFORMANT Mrs. Juanita C. Queen					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma Esophagus 150 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One year			19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 150 X					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A M P M 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE J. E. W. Hitt			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 12-27-68					
EXAMINER'S NAME (Type) J. E. W. HITT			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12-28-1968			23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery					
24. FUNERAL DIRECTOR John R. Watson of Hagerstown Md.			25a. REC'D BY REGISTRAR DEC 31 1968			25b. REGISTRAR'S SIGNATURE Charles Judge					

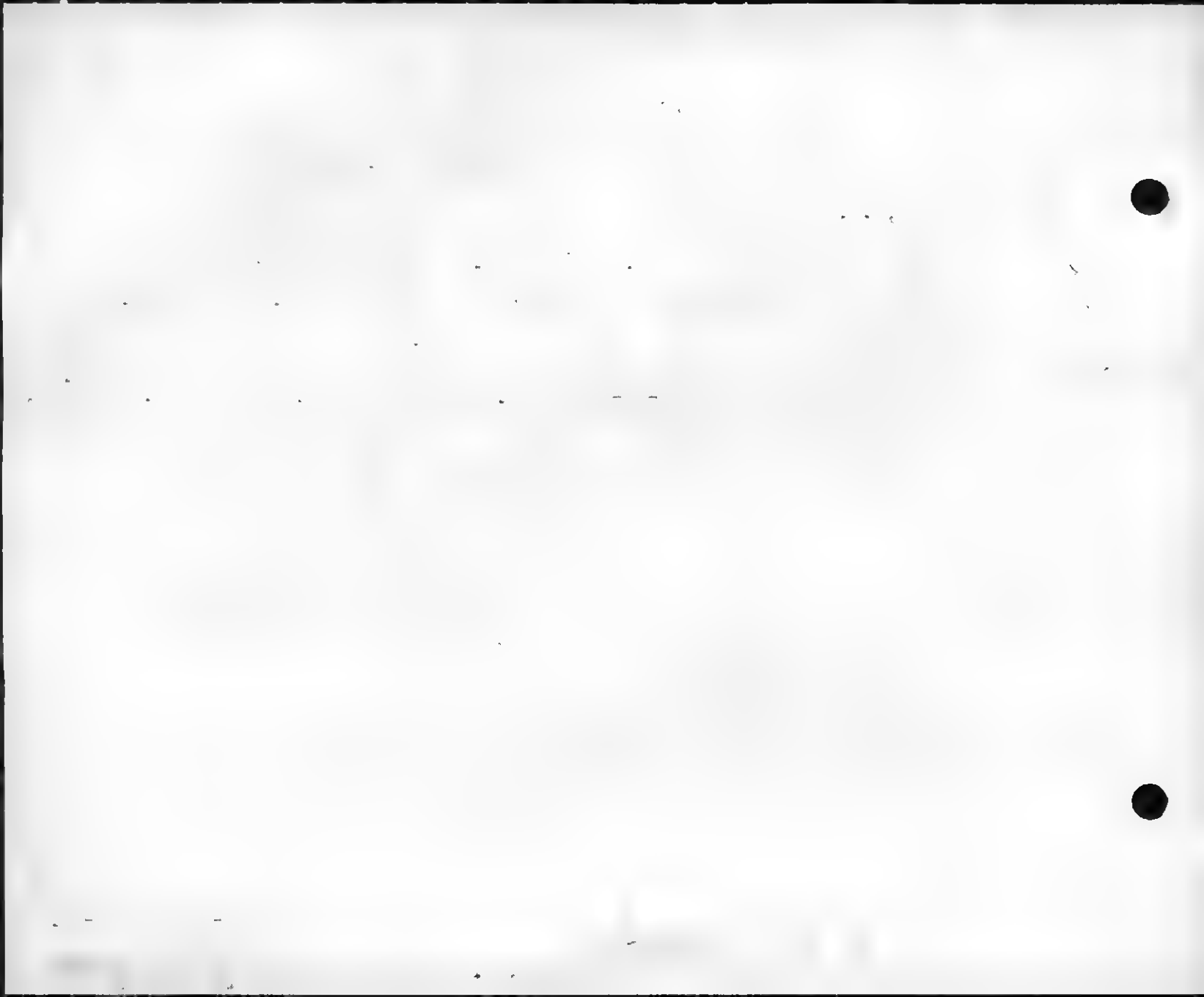


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
18405													
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b. HOUR M				
Maurice Irving Reece						December 15 1968							
3 SEX		4. RACE		5 DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
Male		White		September 4, 1889			79 YRS						
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md	
Brooklyn, N.Y.			USA						Washington				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Bunktown			37 W. Baltimore St.			Heating Contractor			Buildings				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INS. OR CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER	
Maryland			Washington			Bunktown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			37 W. Baltimore St.	
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last										
Stanley M Reece			Cissie L Harne										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17 INFORMANT Address							
No			214-09-8032			Mrs. Bob Creager 37 W. Baltimore St. Bunktown, Md.							
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Artery coronary thrombosis</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b) <u>arteriosclerotic heart disease 1 year</u>													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
420													
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No City or Town County State							
						5-2-1967			Bunktown, Md.				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death													
22b SIGNATURE <u>E. P. Lardner</u>													
22c DATE SIGNED <u>12-16-68</u>													
22d PHYSICIAN'S NAME (Type) <u>E. P. Lardner</u>													
22e ADDRESS <u>301 W. Preston St. Baltimore, Md.</u>													
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Burial			12/18/68			Rest Haven Cemetery			Hagerstown-Washington-Md.				
24. FUNERAL DIRECTOR <u>Wm. C. Wood</u>						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Rest Haven Funeral Chapel Hagerstown, Md.						DATE DEC 19 1968			f Charles Judge				

MEDICAL CERTIFICATION



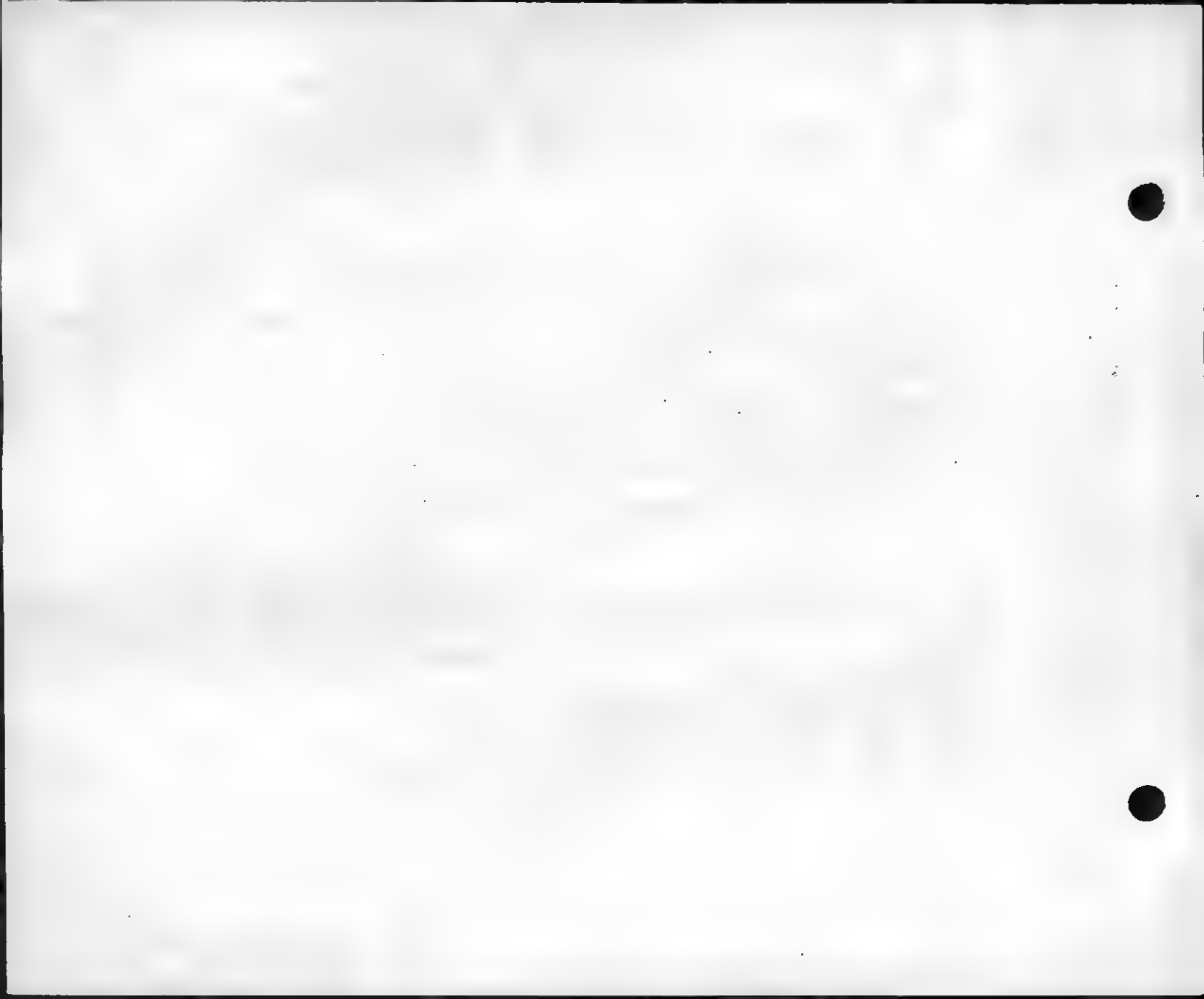
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
18303
CERTIFICATE OF DEATH
18406

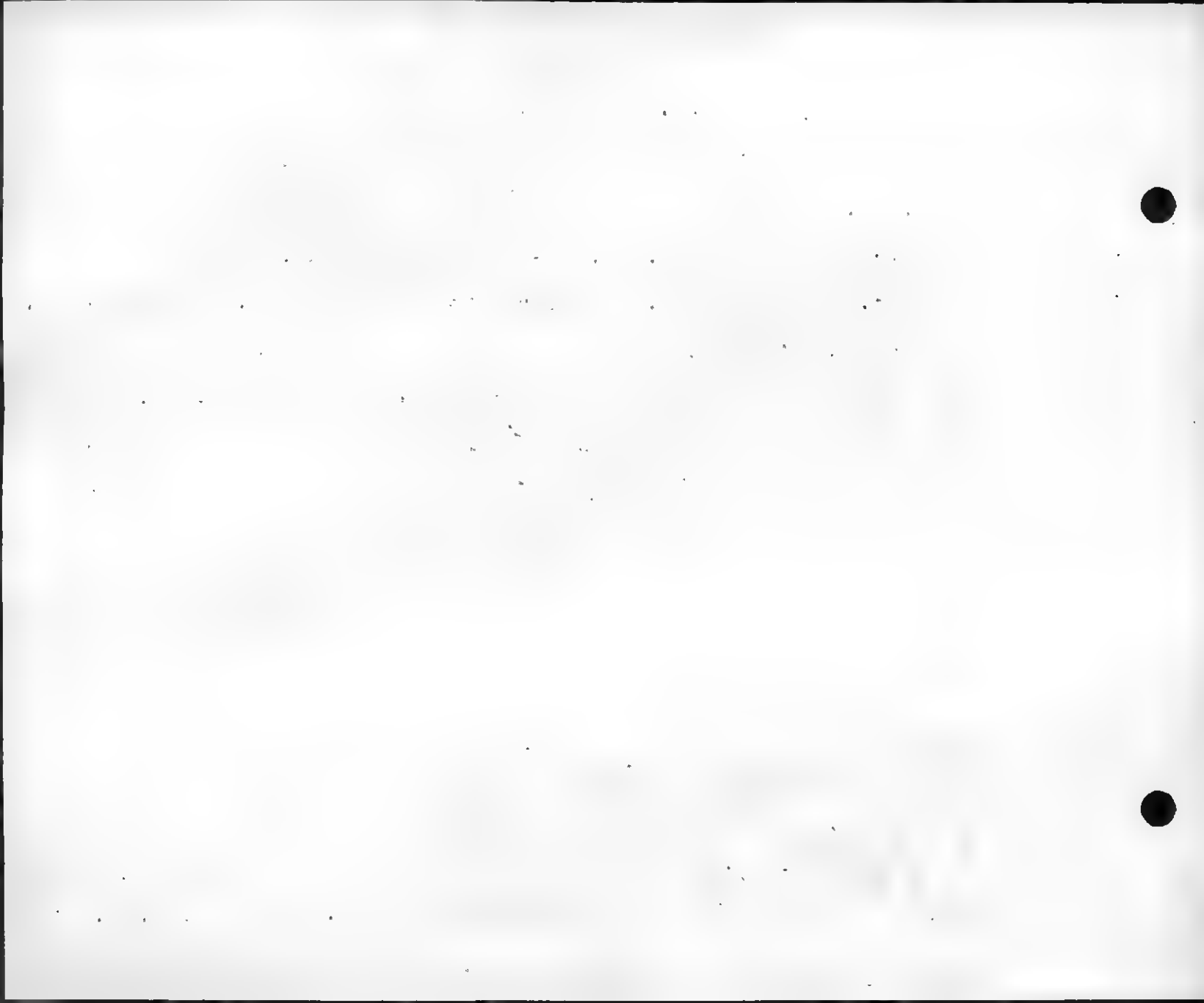
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagers Town</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hancock MD RD2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>Washington Co - MD.</u>			
3. NAME OF DECEASED (Type or print) <u>James Roscoe Reel Jr.</u>				4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>1968</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>April 17 1922</u>	9. AGE (In years last birthday) <u>46 yrs.</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Stone & Concrete</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington Co - MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>				13. FATHER'S NAME <u>James R Reel Sr.</u>			
14. MOTHER'S MAIDEN NAME <u>Francis Norris</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>212-32-3673</u>				17. INFORMANT <u>Mrs. Mary J Reel RD2 Hancock MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured acute dissecting aneurysm of aorta</u> <u>441.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>431X</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>12/16, 1968</u> , to <u>12/17, 1968</u> , that (I) (we) last saw the deceased alive on <u>12/17 1968</u> , and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John H. Hornaker</u>				22b. DATE SIGNED <u>12-18-68</u>		22c. PHYSICIAN'S NAME (Type) <u>JOHN H. HORNAKER</u>	
22d. ADDRESS <u>154 W. Washington St. Hagers Town - Md</u>				22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 20 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Tonoloway</u>		23d. LOCATION (City, town or county) (State) <u>Fulton Pa.</u>	
24. FUNERAL DIRECTOR <u>Howard Spies</u>				24a. ADDRESS <u>Harrisonville, Pa.</u>		24b. REC'D BY REGISTRAR <u>DEC 23 1968</u>	
24c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				24d. ADDRESS <u></u>			



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Vina Virginia Rhoe						12 Month 24 Day 68 Year			M
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
female		white		May 18, 1905			63 YRS.		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
W. Va.		USA				Washington Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown			Wash. Co. Hospital			housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Wash.		Hagerstown			759 W. Washington St.	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Hammond Allright				Mamie Lutman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
no			none		James Rhoe Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Exhaustion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Long continued strain</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs</u> <u>24 hrs</u> <u>Several years</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/24/68</u> , 19 <u>68</u> , to <u>12/24/68</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>12-24-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. W. D. Little Jr.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED <u>12-27-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>W. D. Little Jr.</u>								22e. ADDRESS <u>315 W. Washington Hagerstown Md.</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12-27-68		Providence Cemetery		Providence, W. Va.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Minnich Funeral Home Hagerstown, Md.				DATE DEC 30 1968		<u>Charles Judge</u>			



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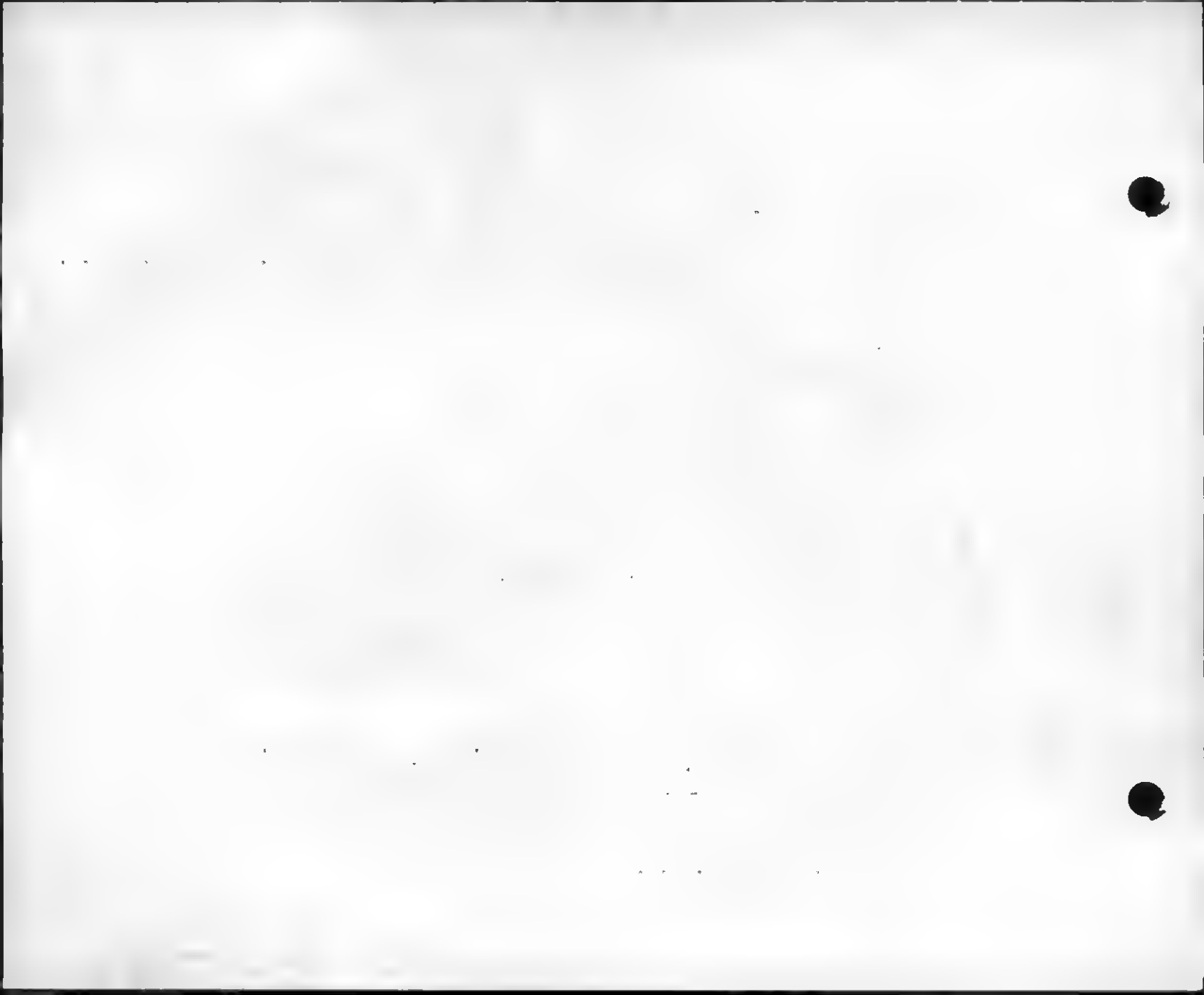
18395										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										18408									
1 DECEASED-NAME (Type or print) First Middle Last										2a. DATE OF DEATH Month Day Year										2b. HOUR									
GROVER C. RICHISSON										Dec. 29, 1968										11:30 P.M.									
3 SEX Male					4. RACE White					5. DATE OF BIRTH Apr. 24, 1888					6 AGE (In years last birthday) 80 YRS.					7 UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN				
7a. BIRTHPLACE (State or foreign country) Penna.					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Washington Md.														
10 CITY OR TOWN OF DEATH Hagerstown					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Avalon Manor					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Tannery worker					12b. KIND OF BUSINESS OR INDUSTRY Leather														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pa.					13b. COUNTY Franklin					13c. CITY OR TOWN Mercersburg					13d. INSIDE CITY LIM TSP? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 122 S. Park Ave.									
14. FATHER'S NAME First Middle Last William Richesson					15. MOTHER'S MAIDEN NAME First Middle Last Rebecca Speck																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no					16b. SOCIAL SECURITY NO. 159-09-6603					17. INFORMANT Address Mrs. Eugene Lowans Mercersburg, Pa.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis															2 WKS.														
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis															2 YRS														
DUE TO, OR AS A CONSEQUENCE OF (c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 9-12, 19 68, to 12-29, 19 68, that (I) (we) lost saw the deceased alive on 12-27, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE Lloyd A. Hoffmann DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 12/30/68																			
22d. PHYSICIAN'S NAME (Type) Lloyd A. Hoffmann										22e. ADDRESS 214 N. Potomac St. Hagerstown, Md.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 1/1/69					23c. NAME OF CEMETERY OR CREMATORY Fairview					23d. LOCATION (City or Town) (County) (State) Mercersburg Franklin, Pa.														
24. FUNERAL DIRECTOR F. H. Buringer ADDRESS Mercersburg, Pa.										25a. REG. REGISTRAR DATE JAN 6 1969					25b. REGISTRAR'S SIGNATURE														



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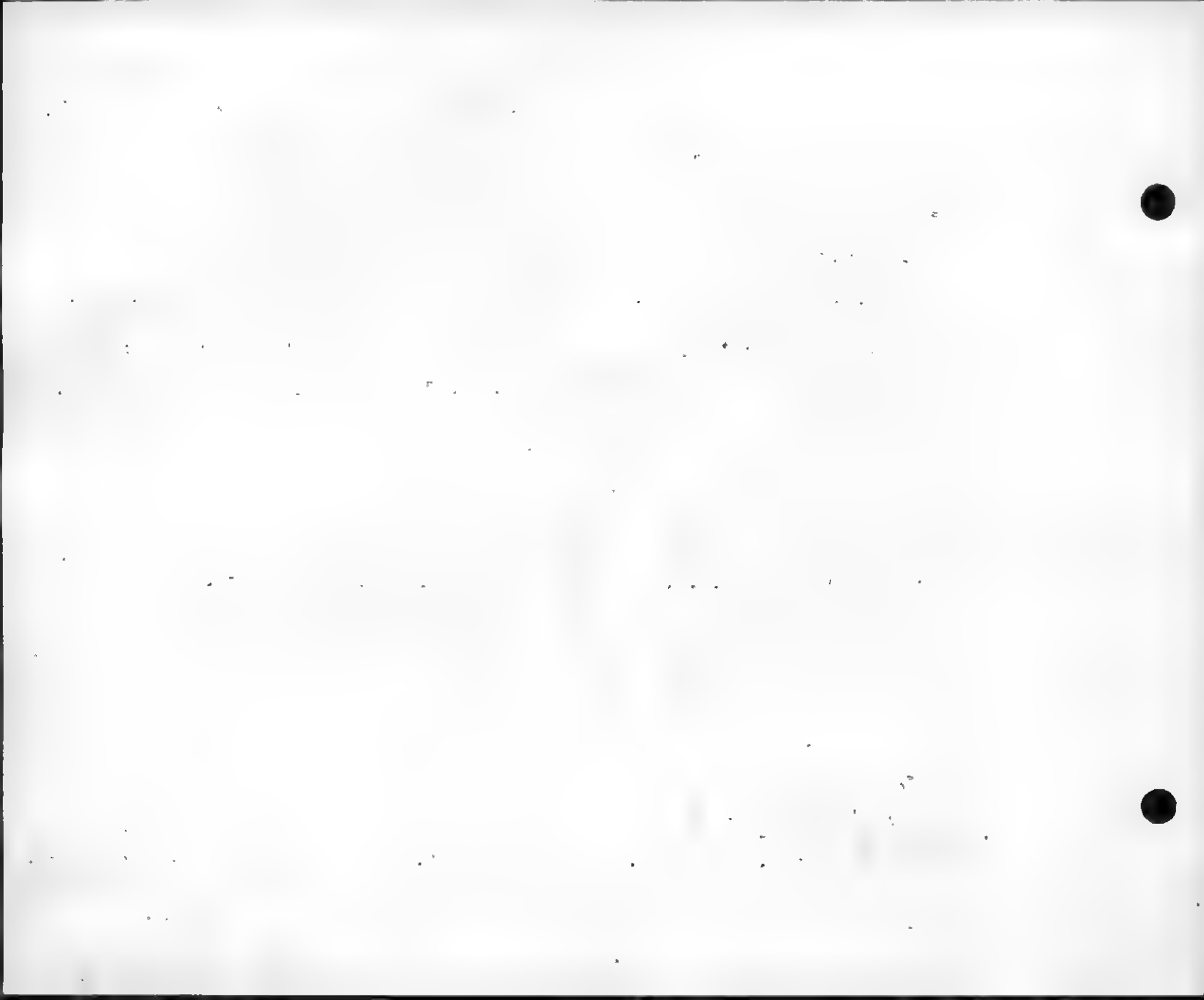
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
18306									
18409									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
STANLEY			BLISS			RILEY			DECEMBER 29 68 4:40aM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
MALE		WHITE		JUNE 19, 1880			88 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH
MARYLAND			U.S.A.			WASHINGTON			Md
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
HAGERSTOWN			WASHINGTON COUNTY HOSP.			RETIRED SUPT.			W.M. R.R.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
MARYLAND			WASHINGTON			HAGERSTOWN			13e. STREET AND NUMBER
									1019 OAK HILL AVE.
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
JOHN H RILEY			MARIA BROWNING						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			
NO			717-10-4071			RT #5 Address BOX 191 VIRGINIA HANWAY GRAFTON, WEST VIRGINIA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 600X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>600X</u> (b) <u>Pelvic thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Not known</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerotic heart disease; benign prostate hypertrophy</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
12/6/68		Benign prostate hypertrophy			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) this hospital attended the deceased from <u>Dec. 2</u> , 19 <u>68</u> , to <u>Dec. 29</u> , 19 <u>68</u> , that (I) was last saw the deceased alive on <u>Dec. 28</u> , 19 <u>68</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) (did not) view the body after death.									
22b. SIGNATURE <u>B.B. Kneisley M.D.</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/30/68	
22d. PHYSICIAN'S NAME (Type) B.B. KNEISLEY, M.D.						22e. ADDRESS 148 W. WASHINGTON ST., HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		1/1/69		REST HAVEN CEMETERY		HAGERSTOWN, WASHIN. TON, MD.			
24. FUNERAL DIRECTOR <u>Charles M. Leizer</u>						ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR JAN 2 1969	
								25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>18397</div> <div> <div>18410</div> <div>CERTIFICATE OF DEATH</div> </div>																	
1 DECEASED NAME (Type or print)			First Helen			Middle Rebecca			Last Robinson			2a. DATE OF DEATH Month 12-3-1968 Day Year			2b. HOUR 11:35 P. M.		
3 SEX female			4 RACE white			5 DATE OF BIRTH 3-21-1891			6 AGE (In year lost birth day) 77 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington Md.								
10. CITY OR TOWN OF DEATH Hagerstown			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Avalon Manor			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) Stitcher			12b. KIND OF BUSINESS OR INDUSTRY Shoe, Mfg.								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY Wash.			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 55 E. Franklin, St.					
14. FATHER'S NAME First William Shirey			Middle Last			15 MOTHER'S MAIDEN NAME First Katherine Heffelman			Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-09-5493			17 INFORMANT Mrs. Evelyn Morrison			Address Hagerstown, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cystitis-Pyelitis 575 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 605X (b) Chronic Urinary Retention DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 8 weeks					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Brain Syndrome due to old C.V.A., Hypertensive & Atherosclerotic Heart Disease																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from Oct 30, 1968, to Dec 3, 1968, that (I) (we) lost saw the deceased alive on Dec 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) (did not) view the body after death.																	
22b. SIGNATURE W. T. Layman, M.D.			DEGREE ATTENDING PHYS.			<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED Dec 4 1968								
22d. PHYSICIAN'S NAME (Type) William T. Layman, M.D.			22e. ADDRESS 301 E. Antietam Street, Hagerstown, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12-6-1968			23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.								
24 FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.			ADDRESS			25a. REC'D BY REGISTRAR DATE DEC 9 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

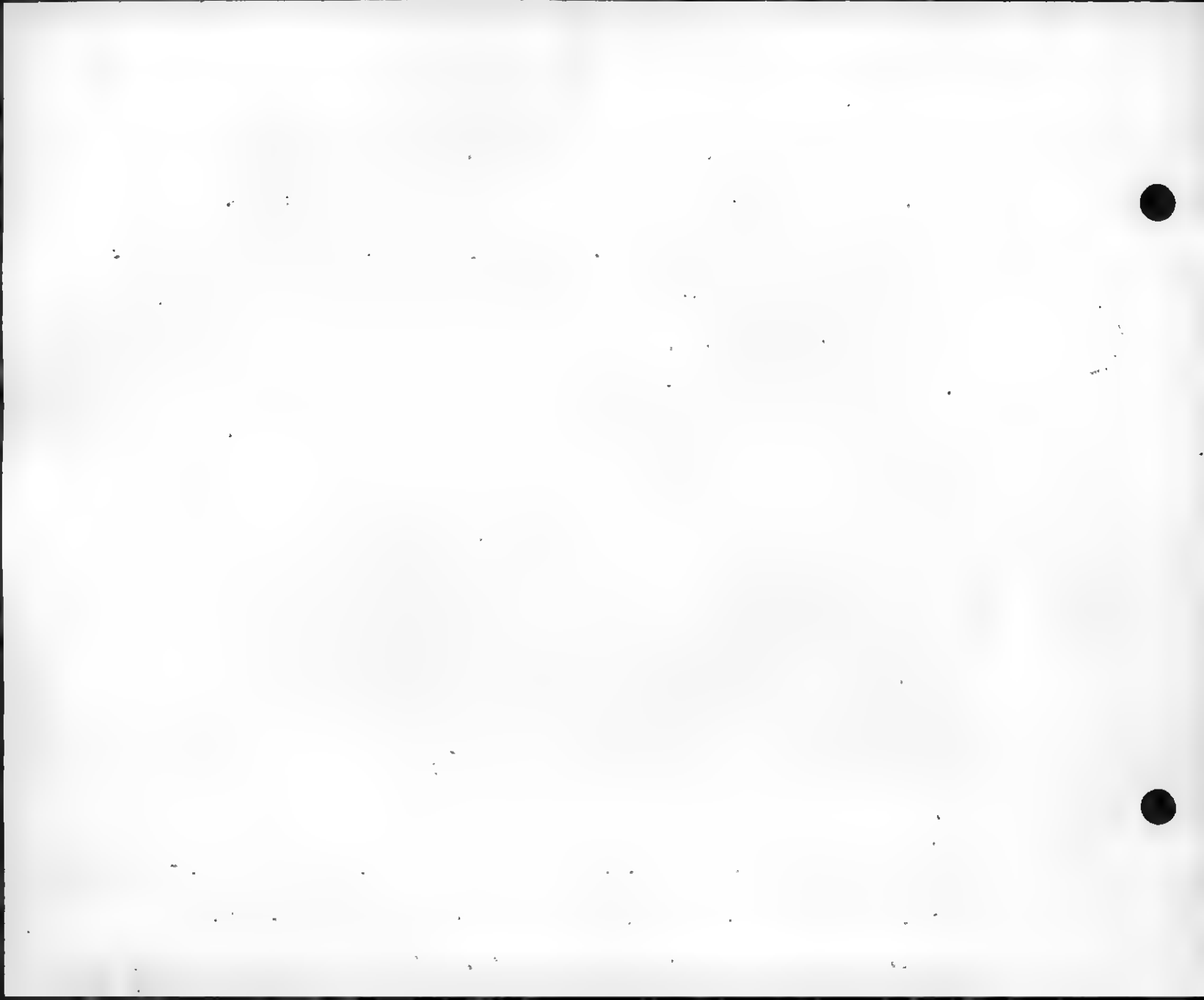
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18303

10411

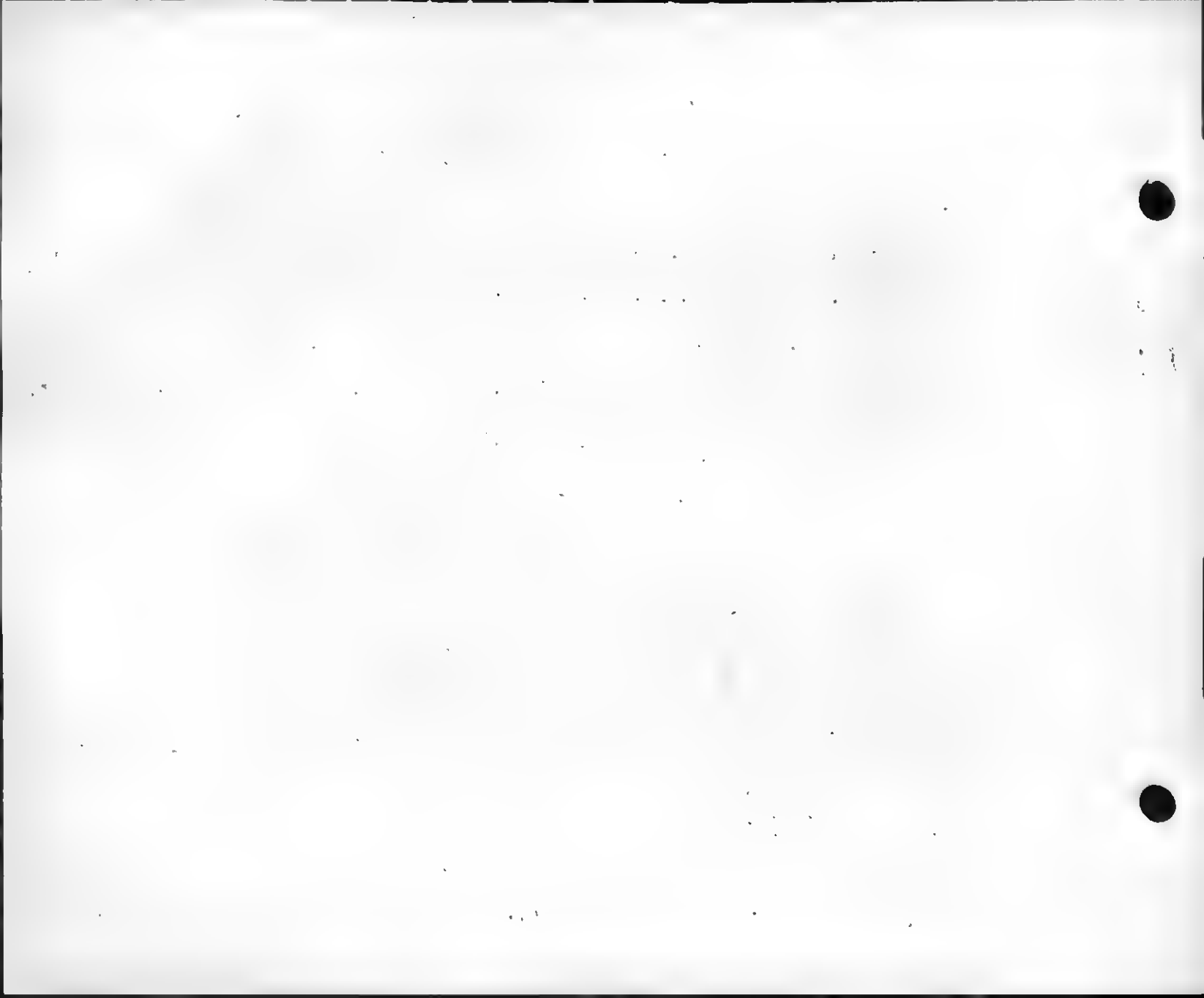
1. DECEASED-NAME (Type or print) Eva First Monroe Middle Rowe Last			2a. DATE OF DEATH 12 Month 20 Day 68 Year			2b. HOUR M					
3 SEX female		4 RACE white		5 DATE OF BIRTH Dec. 14, 1918		6 AGE (In years last birthday) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Washington Md.					
1d. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Wrapper			12b. KIND OF BUSINESS OR INDUSTRY Bread Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 926 Salem Ave.		
14. FATHER'S NAME First Charles Middle Spidelle Last			15. MOTHER'S MAIDEN NAME First Susan Middle Hart Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 213-16-1567		17. INFORMANT Address Woodrow Rowe Hagerstown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Pneumonia DUE TO, OR AS A CONSEQUENCE OF Aplastic Anemia									BETWEEN ONSET AND DEATH 2 Days		
									2 Days		
									1 Year		
									PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Probable Streptococcal Septicemia		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12-18, 1961 , to 12-26, 1968 ; that (I) (we) last saw the deceased alive on 12-25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles F. Hess M.D. DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 12-27-68					
22d. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.						22e. ADDRESS Smithsburg, Maryland 21783					
23a. BURIAL, CREMATION, BENEFIT (Specify)			23b. DATE 12-28-68		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.			
24. FUNERAL DIRECTOR Minnich Funeral Home ADDRESS Hagerstown, Md.						25a. REC'D BY REGISTRAR DATE DEC 31 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 18309 MARYLAND STATE DEPARTMENT OF HEALTH 18412 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>											
1. DECEASED-NAME (Type or print) First Middle Last John Amos Rowland						2a. DATE OF DEATH Month Day Year December 13, 1968			2b. HOUR 12:37 A.M.		
3. SEX male		4. RACE white		5. DATE OF BIRTH 10-26-1904			6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.					
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. County Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Guard			12b. KIND OF BUSINESS OR INDUSTRY Correctional Inst.		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 4 Hampton, Road		
14. FATHER'S NAME First Middle Last Issac D. Rowland						15. MOTHER'S MAIDEN NAME First Middle Last Lydia M. Shank					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. WW 11			17. INFORMANT Address Mrs. Janice K. Rowland Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u> <u>1 1/2 hours</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4. none</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (1) (this hospital) attended the deceased from <u>Jan 1962</u> to <u>Dec 13, 1968</u> , that (1) (we) last saw the deceased alive on <u>Dec 13, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>M.E. Byrkit</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>Dec 14, 1968</u>			
22d. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>		22e. ADDRESS <u>Williamsport Md</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-15-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Quincy Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Quincy, Pennsylvania</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Minnich Funeral Home Hagerstown, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>DEC 16 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

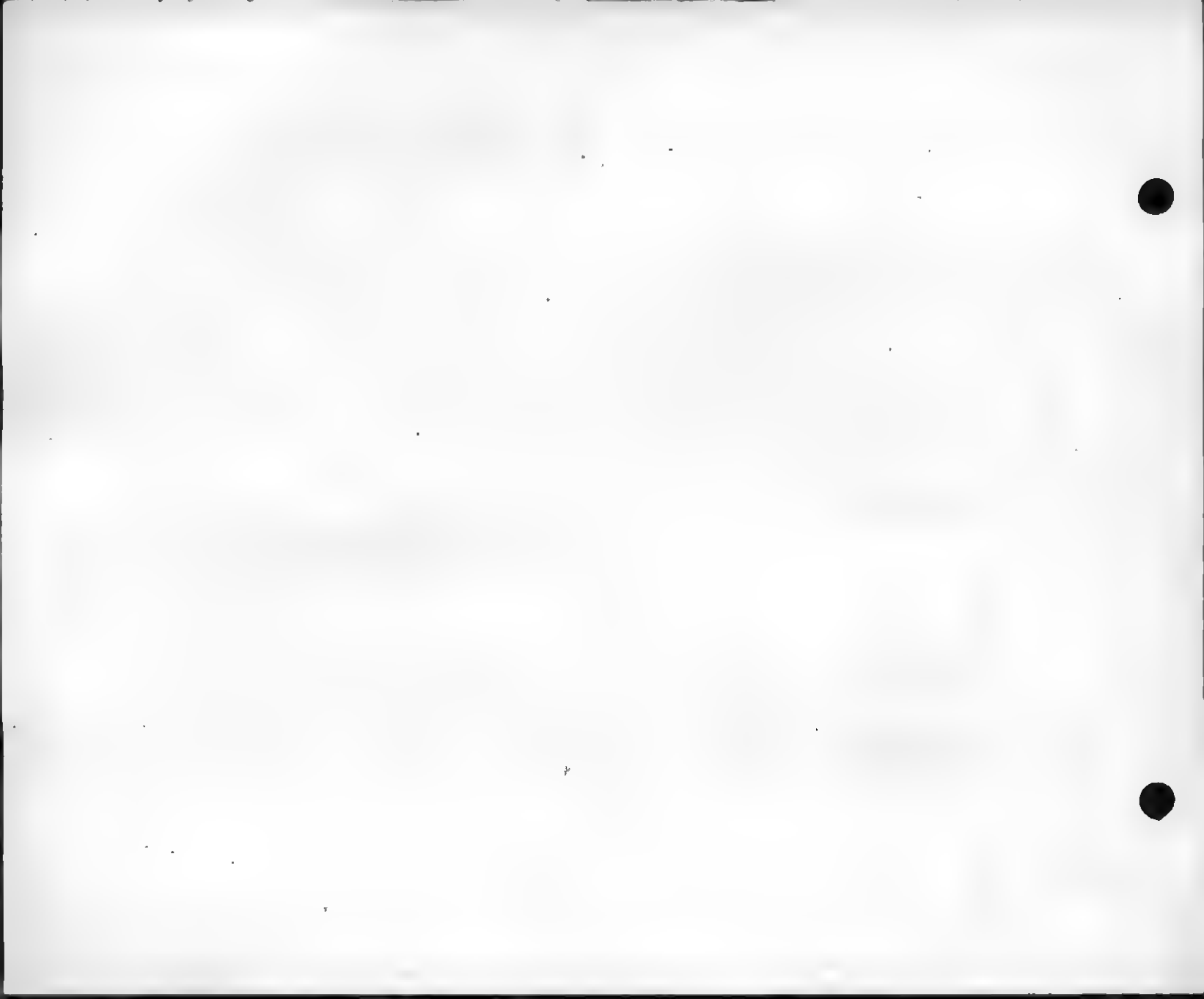


FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First		Middle		Last		
GEORGE			JAMISON		RUCH				
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS		MIN
Male	W	NOVEMBER 17, 09		59	YRS				
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH		
WEST VIRGINIA			U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Washington Md		
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
Leitersburg Pike				ROUTE #5			A.M. WORKER		FAMILY
13a USUA. RESIDENCE (Where deceased lived if institution. Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER
MARYLAND				WASHINGTON		HAGERSTOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	ROUTE #5
14. FATHER'S NAME				First		Middle		Last	
JOHN				ALBERT		RUCH			
15 MOTHER'S MAIDEN NAME				First		Middle		Last	
SARAH				JANE		DALBY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT			
UNKNOWN				235-03-3045		FRANK HARLESS CHARLESTON, WEST VIRGINIA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Basal skull fracture and compound fracture of right tibia and fractured right femur</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>right femur</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>8129</u>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR <u>9:14</u> PM <u>12-10-68</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Struck by vehicle</u>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Leitersburg Pike</u>		21f. LOCATION Street or R.F.D. No		City or Town		County	State
						Washington, Md.			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Howard N. Weeks</u>				M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)				Howard N. Weeks, Hagerstown		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		12/11/68	
						ADDRESS (Street, city, town, or county)		Washington	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
BURIAL		12/13/68		SPRING HILL CEMETERY		CHARLESTON		W. VA.	
24 FUNERAL DIRECTOR <u>Charles S. Ruzer</u>				ADDRESS HAGERSTOWN, MARYLAND		25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
						DEC 16 1968			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper sheets 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Walter George Ryan						December 23, 1968			A. M.
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR	
Male	White		March 5, 1893			75 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Ohio		U.S.A.				Washington		Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Williamsport			2733 Virginia Ave.			Inspector-Fairchild Retired			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Washington		Wmsport		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2733 Virginia Ave.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
No Record			No Record						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
No			214-09-7398		William Burhams Jr.		Hagerstown Md. 230 Potomac Hgts.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Acute coronary occlusion									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Atherosclerotic heart disease									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Gouty arthritis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
none		-		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. none 19		none					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County	State
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		none		-		-		-	-
22a. I certify that (I) (this hospital) attended the deceased from Jan 19 61, to Dec 19 63, that (I) (we) last saw the deceased alive on Dec 16 19 63, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED						
Harold K. Tritch Jr.			12/24/68						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
Dr. Harold K. Tritch Jr. MD			302 N. Potomac St Hagerstown, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12/26/68		Rest Haven Cemetery		Hagerstown Wash. Md.			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Hagerstown, Maryland			DEC 27 1968			Charles Judge			
Andrew K. Coffman Funeral Home Inc.									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18402

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18415

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Henry Bushrod Sampsell		2a DATE OF DEATH Month December Day 5 Year 1968		2b HOUR 8:00 A.M.
3 SEX male	4 RACE white	5. DATE OF BIRTH 10-28-1883	6 AGE (In years last birthday) 85 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington Md	
10. CITY OR TOWN OF DEATH Hagerstown	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Avalon Manor	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Motor Man	12b KIND OF BUSINESS OR INDUSTRY Utilities	
13a USUAL RES-DENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b COUNTY Wash.	13c CITY OR TOWN Hagerstown	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 1005 Pope, Ave.
14 FATHER'S NAME First Middle Last William B. Sampsell	15. MOTHER'S MAIDEN NAME First Middle Last Nannie Fuller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown) no (If yes give war or dates of service)	16b SOCIAL SECURITY NO 217-10-9364	17 INFORMANT Address Mrs. John Pangborn Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis due to 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arterio-sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Loranthus mellitus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Nov 24-68 Many years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arterio-sclerosis Heart Disease				
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from Dec 2, 1967 to Dec 5, 1968 , that (I) (we) last saw the deceased alive on Dec 5, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Sidney Novenstein MD	DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 12-5-68		
22d PHYSICIAN'S NAME (Type) FUNKSTOWN MD	22e. ADDRESS SIDNEY NOVENSTEIN			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 12-7-1968	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24 FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE DEC 9 1968	25b REGISTRAR'S SIGNATURE J Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

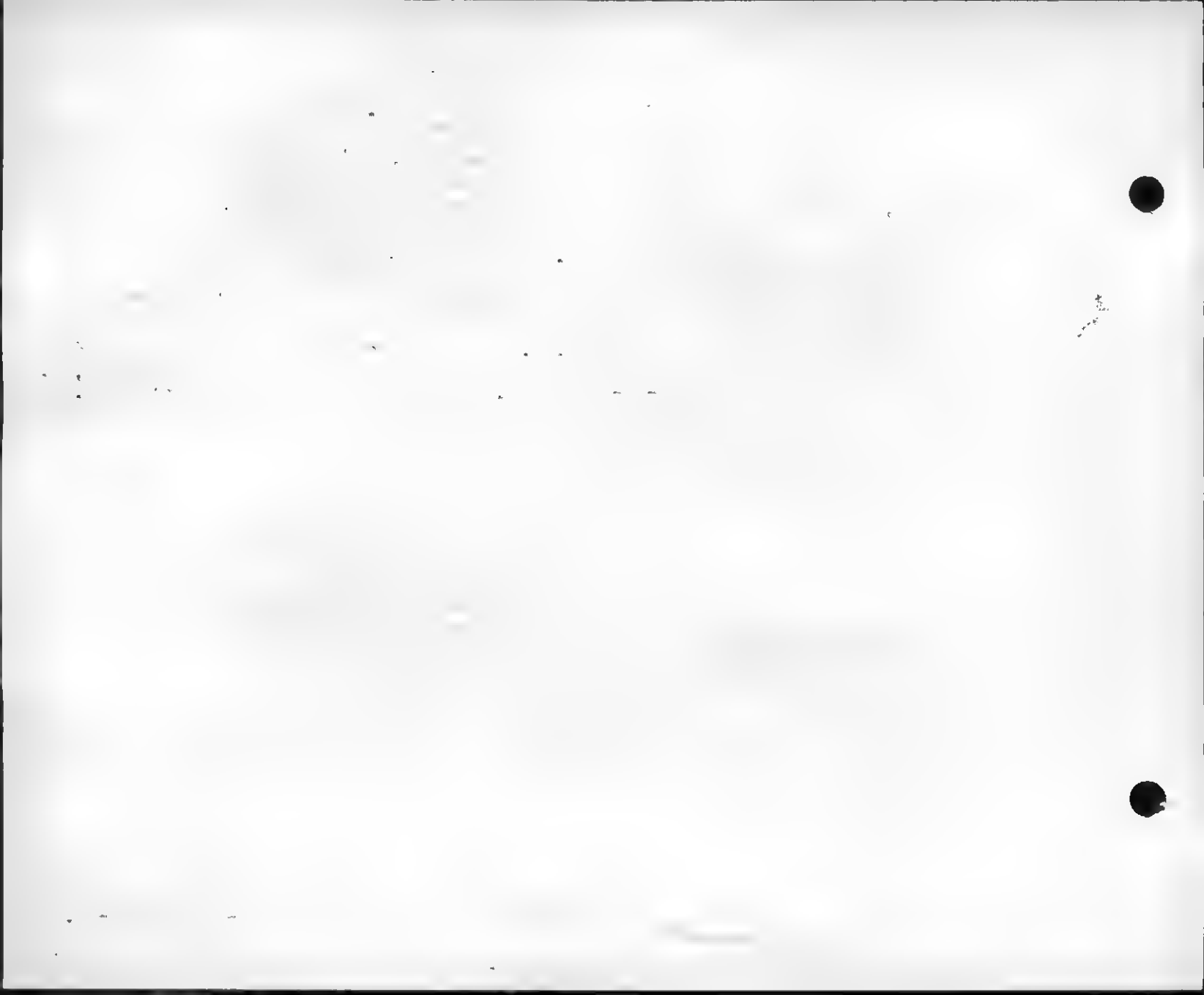
184163

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18416

1. DECEASED-NAME (Type or print) Joseph Hand Scranton, Jr.		2a. DATE OF DEATH Month December Day 30 Year 1968		2b. HOUR M
3 SEX Male	4 RACE White	5. DATE OF BIRTH August 17, 1908	6. AGE (in years lost birthday) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Vergennes, Vermont	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington Md.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Locomotive Engineer	12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1141 Fairview Road
14. FATHER'S NAME First Middle Last Joseph Hand Scranton, Sr.	15. MOTHER'S MAIDEN NAME First Middle Last Leona Farmer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown) (If yes give war or dates of service) No	16b. SOCIAL SECURITY NO. 232-01-8275	17. INFORMANT Address Mrs. Elizabeth Scranton 1141 Fairview Rd. Hagerstown, Md.		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute nephritis 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive athrosclerotic cardio-renal disease. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Sev. yrs.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 44				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING () OR CONTRIBUTING () CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While () Not while () at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 1955 to 12/30 , 1968, that (I) (we) last saw the deceased alive on 12/30 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Howard N. Weeks, M. D.				22c. DATE SIGNED 1/2/69
22d. PHYSICIAN'S NAME (Type) Howard N. Weeks, M. D.		22e. ADDRESS 580 Northern Ave., Hagerstown, Md.		
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/2/69	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown-Washington-Md.	
24. FUNERAL DIRECTOR Rest Haven Funeral Chapel		25a. REC'D BY REG. STRAR DATE JAN 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove casket papers. Pag. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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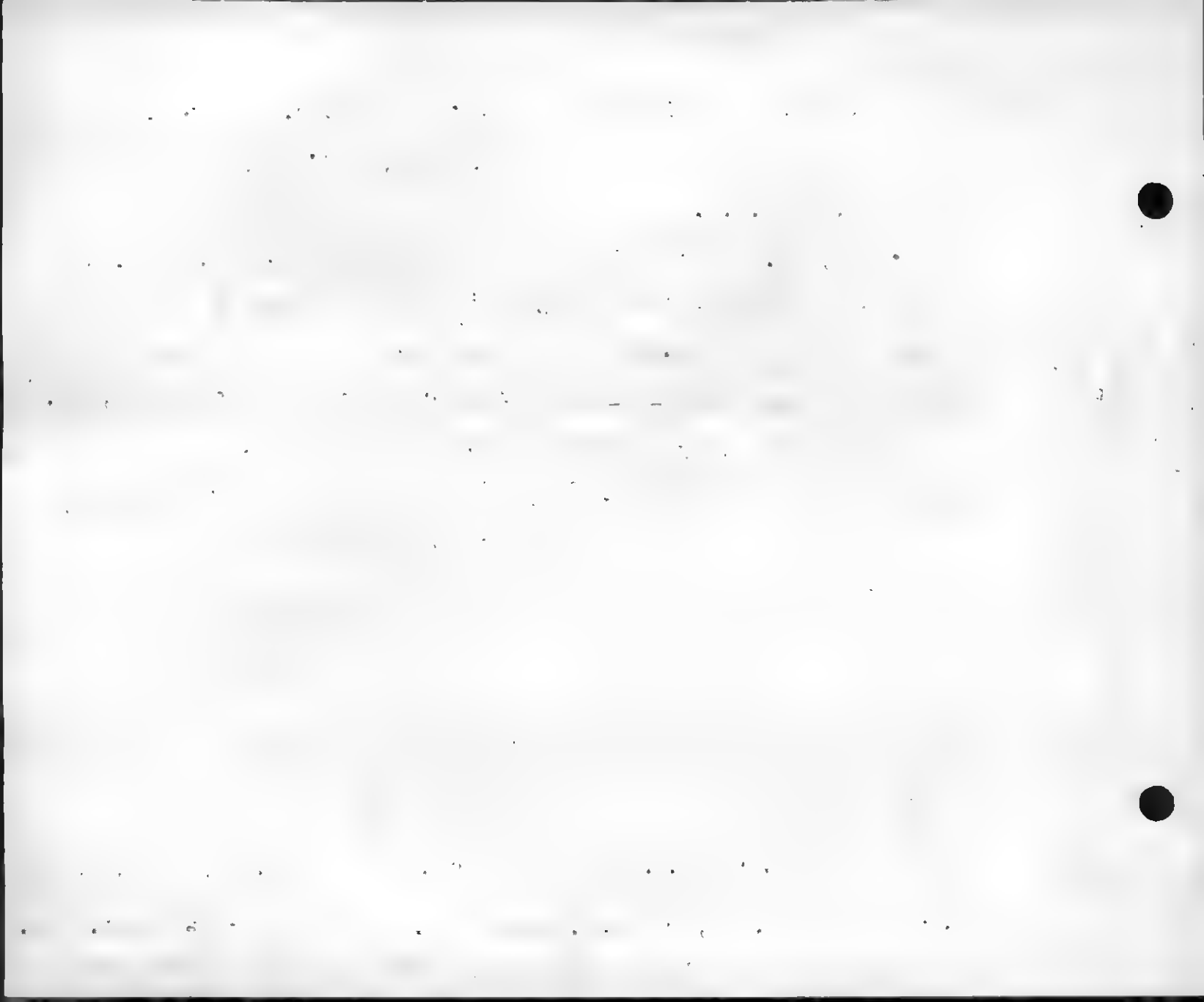
184174

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

18417

1 DECEASED-NAME (Type or print) First Middle Last Millard Filmore Shank			2a. DATE OF DEATH Month Day Year Dec. 9 1968		2b. HOUR M
3 SEX Male	4 RACE White	5. DATE OF BIRTH April 14, 1877		6 AGE (In years last birthday) 91 YRS.	IF UNDER 24 HRS MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (State or foreign country) Shanktown, Md	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington Md.		
10 CITY OR TOWN OF DEATH Big Spring, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rural 1	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Foreman retired	12b. KIND OF BUSINESS OR INDUSTRY Co. Roads		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Washington	13c CITY OR TOWN Big Spring	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER Rural 1	
14. FATHER'S NAME First Middle Last Jacob # Shank	15 MOTHER'S MAIDEN NAME First Middle Last Angeline # Eddy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No	16b. SOCIAL SECURITY NO. None	17 INFORMANT Address Miss Marion Shank Big Spring, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart Disease DUE TO, OR AS A CONSEQUENCE OF (b) advanced generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis obliterans PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4x hypertensive hypertrophy, benign					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 yrs 30 yrs
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.	21f LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Sept 23, 1968 , to Dec 4, 1968 , that (I) (we) last saw the deceased alive on Oct 5, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward W. Ditto M.D.		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 12-10-68		
22d. PHYSICIAN'S NAME (Type) Edward W. Ditto M.D. 111		22e ADDRESS 217W. Washington St. Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec. 12, 1968	23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cem.	23d. LOCATION (City or Town) (County) (State) Western Pike Wash. Md.		
24. FUNERAL DIRECTOR Margaret Rowland		ADDRESS Clear Spring, Md.	25a. REC'D BY REGISTRAR DATE DEC 16 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	

MD 113-41
300-1-68



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-68

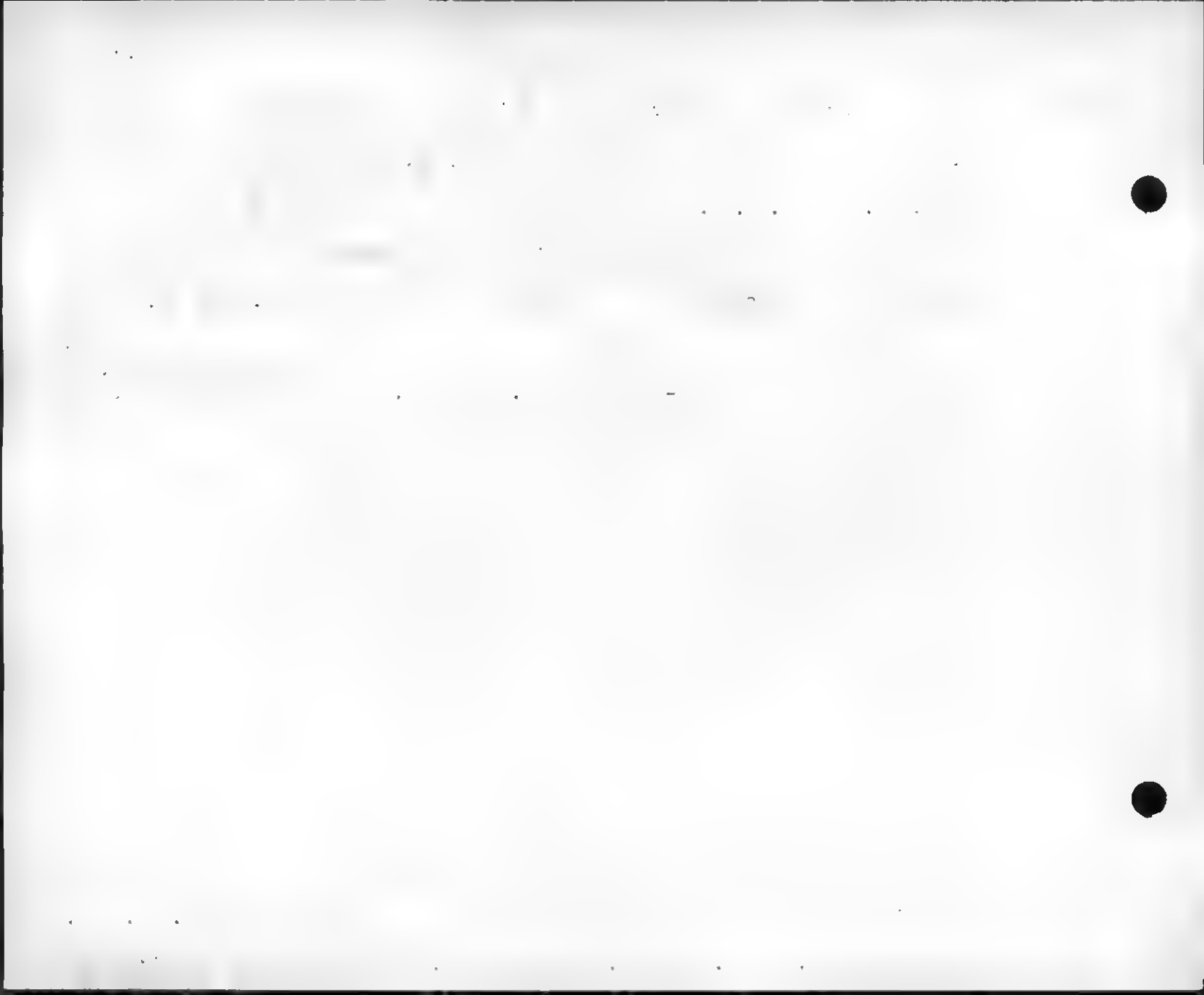
184195

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18418

1. DECEASED NAME (Type or print) Arthur Clyde Shifler			2a. DATE OF DEATH Month December Day 14 Year 1968			2b. HOUR 4:10A M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH March 26, 1884		6 AGE (In years last birthday) 84 YRS.	
7a. BIRTHPLACE (State or foreign country) Monroe, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.	
10 CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Avalon Manor Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 50 St. Paul St.		14. FATHER'S NAME First Middle Last Otho Shifler		15. MOTHER'S MAIDEN NAME First Middle Last Arbelia Doub			
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown) No.		16b. SOCIAL SECURITY NO. 216-14-6245		17 INFORMANT Mrs. Gussie E. Shifler, Boonsboro, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cancer of Stomach 151X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo 3 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 151X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Sept 10, 1968 , to Dec 14, 1968 , that (I) (we) last saw the deceased alive on Dec 11, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. W. Lellan M.D.		22c. DATE SIGNED 12-14, 68		22d. PHYSICIAN'S NAME (Type) G. W. Lellan M.D.			
22e. ADDRESS Boonsboro Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-17-68		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery	
23d. LOCATION (City or Town) (County) (State) Boonsboro, Wash. Co., Md.		24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR DEC 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1/68

<div style="display: flex; justify-content: space-between;"> 18196 MARYLAND STATE DEPARTMENT OF HEALTH </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div> 18419												
1 DECEASED-NAME (Type or print) Edward First Middle E Last Shipe						2a. DATE OF DEATH Month December Day 27 Year 1968			2b. HOUR 3:40PM			
3. SEX Male		4 RACE White		5. DATE OF BIRTH August 18, 1875			6. AGE (In years last birthday) 93 02 YRS.		IF UNDER 1 YEAR MONTHS 00 DAYS 00		IF UNDER 24 HRS. HOURS 00 MIN. 00	
7a BIRTHPLACE (State or foreign country) W.Va.		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.						
10 CITY OR TOWN OF DEATH HAGERSTOWN		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter			12b KING OF BUSINESS OR INDUSTRY --			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 145 So Locust St				
14 FATHER'S NAME First Luther Middle Shipe Last Shipe				15 MOTHER'S MAIDEN NAME First Lana Middle Shipe Last Shipe								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) ---		16b. SOCIAL SECURITY NO 183-07-7833		17 INFORMANT Address Mrs Belle Clark 145 So Locust St Hagerstown								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) unknown										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 8 Day 28 Year 1967		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. 145 So Locust St City or Town Hagerstown County Washington State Md								
22a. I certify that (I) (this hospital) attended the deceased from 8/28 , 19 67 , to 12/27 , 19 68 , that (I) (we) lost saw the deceased alive on December 27, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Domingo A. Garcia DEGREE M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/27/68				
22d. PHYSICIAN'S NAME (Type) Domingo A. Garcia, M.D.						22e. ADDRESS Western Maryland State Hospital Hagerstown, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/30/68		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) Hagerstown (County) Wash (State) Md						
24 FUNERAL DIRECTOR Hagerstown Md ADDRESS Andrew K. Coffman Funeral Home Inc						25a. REC'D BY REGISTRAR DEC 31 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

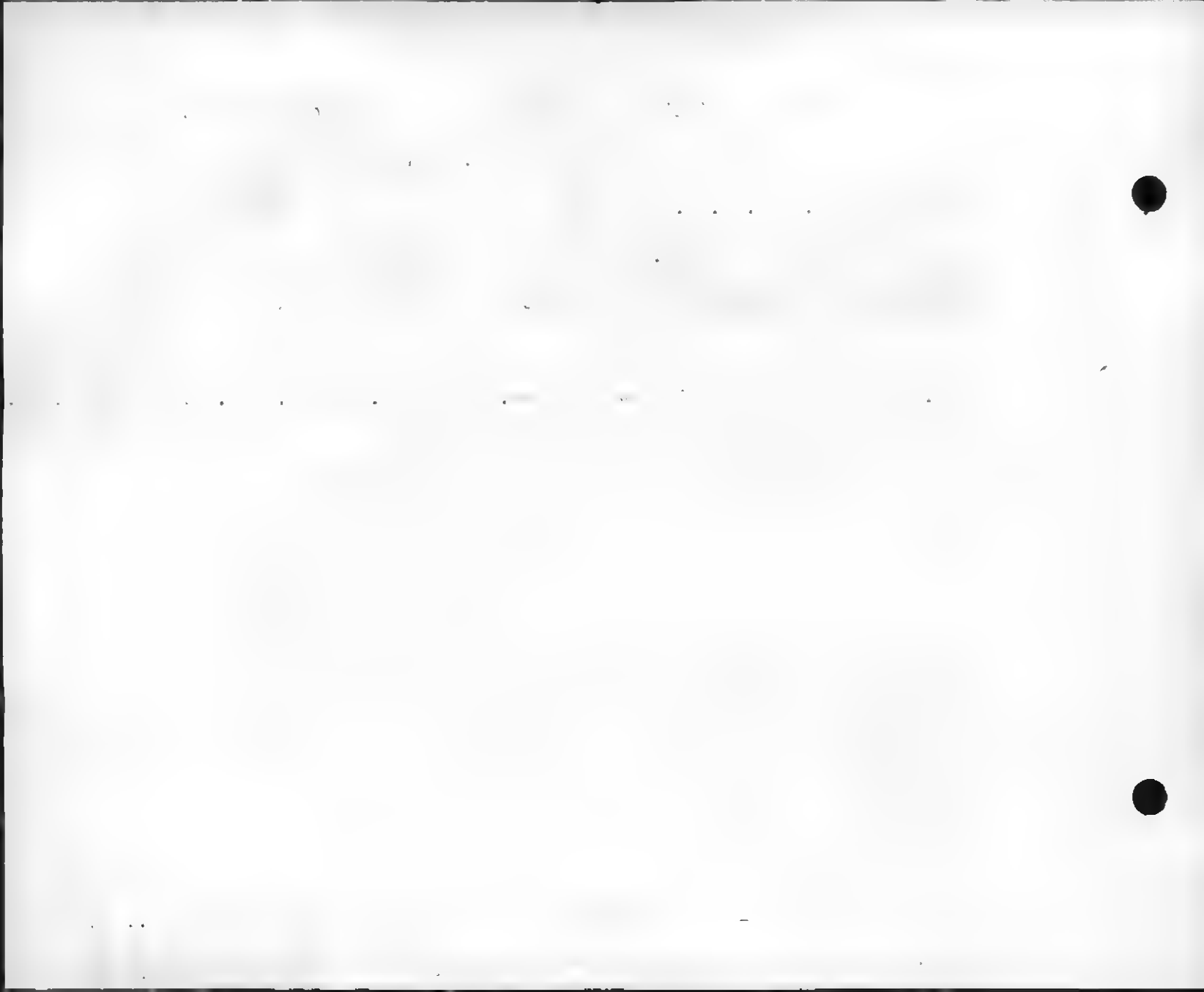
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RECEIVED
DEC 31 1968

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

18420

1. DECEASED NAME (Type or print) Harold William Sigler			2a. DATE OF DEATH Month December Day 27 Year 1968			2b. HOUR 9:00A M								
3. SEX Male		4. RACE White		5. DATE OF BIRTH Jan. 16, 1908		6. AGE (In years last birthday) 60 YRS		F. UNDER 1 YEAR MONTHS 11 DAYS 11		IF UNDER 24 HRS HOURS 11 MIN				
7a. BIRTHPLACE (State or foreign country) Middletown, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.								
10. CITY OR TOWN OF DEATH Boonsboro			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rfd. 2			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Maintenance			12b. KIND OF BUSINESS OR INDUSTRY Aircraft					
13a. U.S.A. RESIDENCE (Where deceased admission) STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Boonsboro			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Rfd. 2		
14. FATHER'S NAME First John Middle Sigler Last Sigler			15. MOTHER'S MAIDEN NAME First Lucy Middle Bowling Last Bowling											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No.			16b. SOCIAL SECURITY NO. 214-10-4334			17. INFORMANT Mrs. Francis R. Sigler, Rfd. 2, Boonsboro, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion + infarct DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 602422														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from 2 PM , 19 68 , to death , 19 68 , that (I) (we) last saw the deceased alive on 28 Nov , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death														
22b. SIGNATURE John M. Bast, Jr. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED 12/25/68														
22d. PHYSICIAN'S NAME (Type) John M. Bast, Jr. 22e. ADDRESS Hagerstown Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-29-68		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION (City or Town) (County) (State) Boonsboro, Wash. Co., Md.								
24. FUNERAL DIRECTOR ADDRESS John M. Bast, Jr. 112 N. Main St. Boonsboro, Md.						25a. REC'D BY REGISTRAR DEC 31 1968		25b. REGISTRAR'S SIGNATURE Charles Judge						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH		2b. HOUR	
Edwin Bruce Smith										December 27, 1968		M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR		7. UNDER 24 HRS.		
male		white		Sept. 19, 1893			75 YRS		MONTHS		DAYS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Maryland		USA				Washington Md.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown			Wash. Co. Hospital			crane operator			Railroad				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.				Wash.		Hagerstown				523 Jefferson St.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
William Smith				Fannie Boward									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO		17. INFORMANT Address							
no				705-10-5441		Ellen Smith, Hagerstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Peritonitis and ilius											1 WKS		
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 576x													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
Pneumonia, coronary artery disease, emphysema													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
		HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State									
White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>													
22a. I certify that (I) (the hospital) attended the deceased from 12/25/1968, to 12/27/1968, that (I) (we) last saw the deceased alive on 12/27/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE		22c. M.D. DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e. DATE SIGNED							
Howard N. Weeks						12/28/68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS											
		580 Northern Ave., Hagerstown Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
Burial		12-30-68		Rose Hill Cemetery		Hagerstown, Md.							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Minnich Funeral Home, Hagerstown, Md.				DATE DEC 31 1968		Charles Judge							



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VR A15 (4)
30M REV. 1/68

18100										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										18422																								
CERTIFICATE OF DEATH																																												
1. DECEASED-NAME (Type or print)					First EMMA					Middle JANE					Last SMITH					2a. DATE OF DEATH					Month DECEMBER					Day 15					Year 68					2b. HOUR 12.40				
3. SEX FEMALE					4. RACE WHITE					5. DATE OF BIRTH FEBRUARY 26, 1878					6. AGE (In years last birthday) 90					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN																			
7a. BIRTHPLACE (State or foreign country) MARYLAND					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH WASHINGTON Md																													
10. CITY OR TOWN OF DEATH HAGERSTOWN					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) AVALON MANOR NURSING HOME					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOMEMAKER					12b. KIND OF BUSINESS OR INDUSTRY OWN HOME																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND					13b. COUNTY WASHINGTON					13c. CITY OR TOWN HAGERSTOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 227 N. MULBERRY ST.																								
14. FATHER'S NAME					First JEROME					Middle FRITNER					Last CAROLYN					15. MOTHER'S MAIDEN NAME					First UNKNOWN					Middle UNKNOWN					Last UNKNOWN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO					16b. SOCIAL SECURITY NO. 213-10-6892					17. INFORMANT MR. CLAUDE SMITH					227 Address N MULBERRY ST. HAGERSTOWN, MARYLAND																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident															3 days																													
4120 DUE TO, OR AS A CONSEQUENCE OF Hypertensive Cardiovascular Disease															18 years																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X																																												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																												
Urinary Tract Infection. Hemorrhage from G.I. Tract (Nov 68)																																												
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No City or Town County State																																		
22a. I certify that (I) (we) attended the deceased from Nov 18, 1968, to Dec 15, 1968, that (I) (we) last saw the deceased alive on Dec 14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																																												
22b. SIGNATURE W. T. Layman M.D.										DEGREE M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 12/16/68																								
22b. PHYSICIAN'S NAME (Type) WILLIAM T. LAYMAN, M.D.										22c. ADDRESS 301 E ANTIETAM ST., HAGERSTOWN, MD.																																		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE 12/18/68					23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY					23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASHINGTON, MD.																													
24. FUNERAL DIRECTOR Charles M. Ranges										ADDRESS HAGERSTOWN, MARYLAND					25a. REC'D BY REGISTRAR DATE DEC 20 1968					25b. REGISTRAR'S SIGNATURE Charles Judge																								

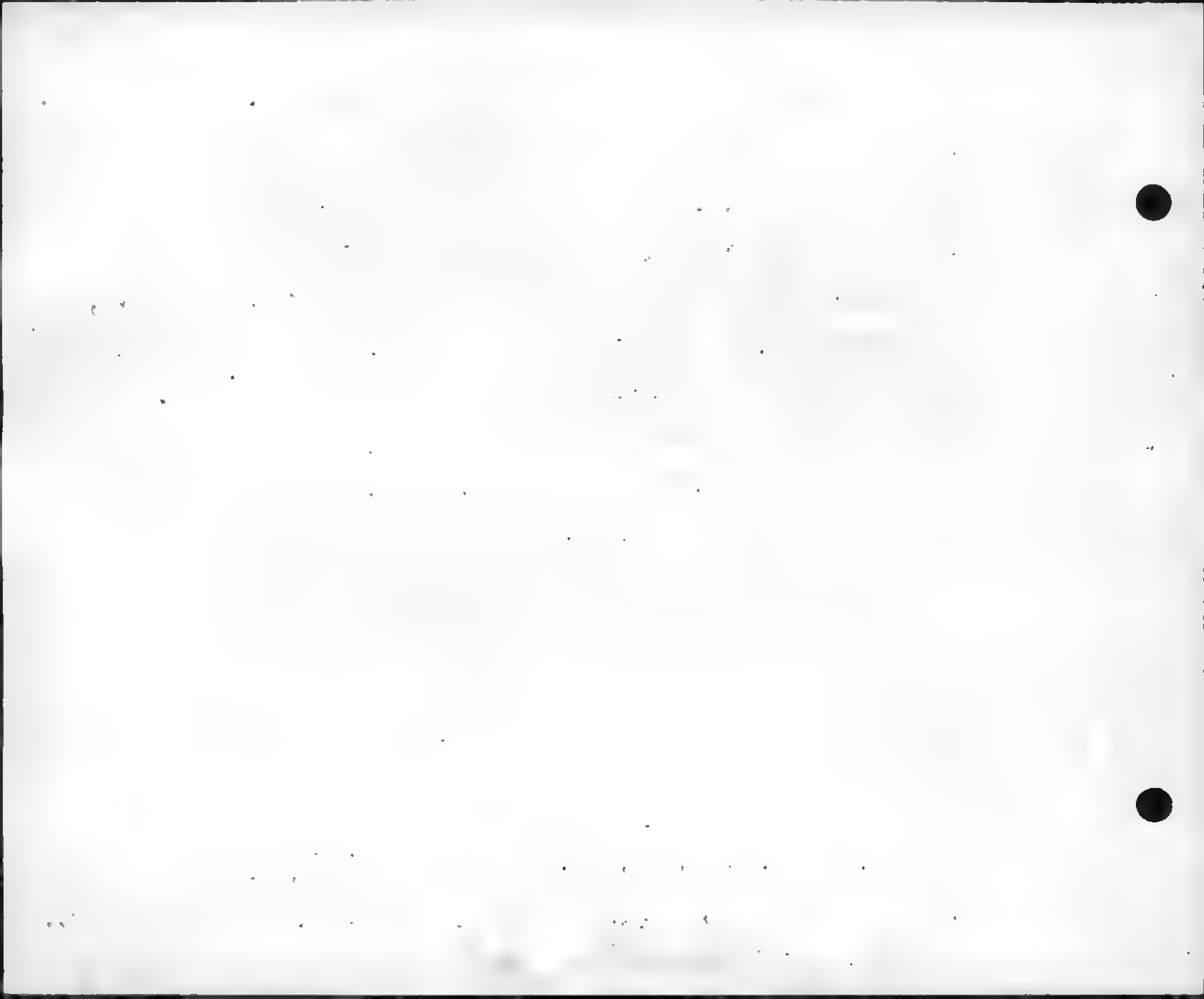
MEDICAL CERTIFICATION



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MIDDLE											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First GLENDORA		Middle GERTRUDE		Last SNYDER		2a. DATE OF DEATH Month 8 Day 1968 Year		2b. HOUR 4A. M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 10/9/1890		6. AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.					
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. COUNTY HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME					
13a. USUAL RESIDENCE (Where deceased admission) MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INS. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 801 OAK HILL AVE.			
14. FATHER'S NAME First Middle Last CHARLES D. WAGAMAN		15. MOTHER'S MAIDEN NAME First Middle Last LULA IANTZ									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO 216-22-7739B		17. INFORMANT HAGERSTOWN MD. MR. JOHN S. SNYDER							
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral lobular pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral thrombosis + complete DUE TO, OR AS A CONSEQUENCE OF (c) rt. hemiplegia 4339 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-5 days 8 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Nov 29, 1968, to Dec 8, 1968, that (I) (we) last saw the deceased alive on Dec 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edward W. Ditto, III, M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>								22c. DATE SIGNED 12-9-68			
22d. PHYSICIAN'S NAME (Type) Edward W. Ditto, III, M.D.		22e. ADDRESS 217 W. Washington Street Hagerstown, Maryland									
23a. BURIAL, CREMATION, or other disposition BURIAL		23b. DATE 12/10/68		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.					
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.		25a. RECD BY REGISTRAR DATE DEC 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER:
 necessary, please execute this certificate
 the funeral director. Page 4 should
 5 may be retained for your files.

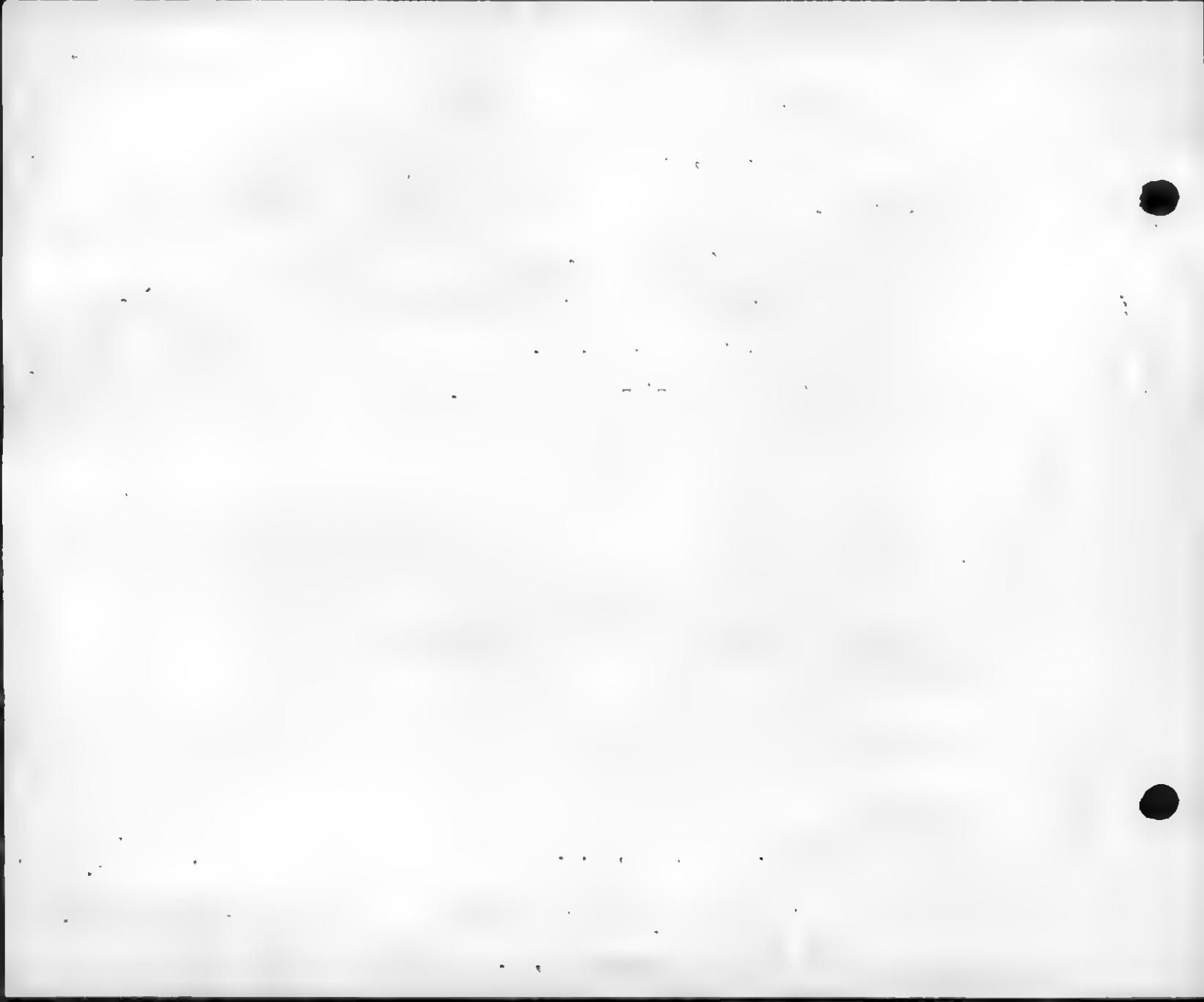
Health prior to burial, cremation, or removal, and in any event within 72 hours after death

Health prior to burial, cremation, or removal, and in any event within 72 hours after death

2

VR A15ME (S)
1DM REV 1/68

<div style="display: flex; justify-content: space-between;"> 18111 MARYLAND STATE DEPARTMENT OF HEALTH 18424 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>											
1. DECEASED NAME (Type or Print) <div style="display: flex; justify-content: space-around;"> First: Ralph Middle: Waldo Last: Snyder </div>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <div style="display: flex; justify-content: space-around;"> 12 18 1968 </div>			2b. HOUR OF DEATH <div style="display: flex; justify-content: space-around;"> 11 22 AM </div>		
3. SEX Male	4. RACE White	5. DATE OF BIRTH July 17, 1901	6. AGE (In years last birthday) 67 YRS	7. UNDER 1 YEAR MONTHS: DAYS: 	8. UNDER 24 HRS HOURS: MIN: 	2c. DATE PRONOUNCED DEAD Month 12 Day 18 Year 1968			2d. HOUR OF DEATH <div style="display: flex; justify-content: space-around;"> 53 PM </div>		
7a. BIRTHPLACE (State or foreign country) Hagerstown, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington			Md.		
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk			12b. KIND OF BUSINESS OR INDUSTRY Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution on residence before admission) STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 424 W. Franklin St.		
14. FATHER'S NAME <div style="display: flex; justify-content: space-around;"> First: Robert Middle: Bruce Last: Snyder, Sr. </div>				15. MOTHER'S MAIDEN NAME <div style="display: flex; justify-content: space-around;"> First: Mae Middle: Mahala Last: Bowen </div>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes			16b. SOCIAL SECURITY NO 213-18-8661A		17. INFORMANT ADDRESS Robert B. Snyder 112 Williams Circle Williamsport, Md.						
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary atherosclerosis - Arteriosclerotic <div style="display: flex; justify-content: space-between;"> 4:09 PM 1/2 - 1 hr. </div> DUE TO, OR AS A CONSEQUENCE OF (b) It coronary due coronary atherosclerosis <div style="display: flex; justify-content: space-between;"> 15-25 yrs </div> DUE TO, OR AS A CONSEQUENCE OF (c) 											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) Pulmonary Emphysema, Benign nephrosclerosis, Prostate hypertrophy											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home farm street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Edward W. Ditto, III EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) 217 W. Washington St. Hagerstown, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12/24/68		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			23d. LOCATION (City or Town) (County) (State) Hagerstown-Washington-Md.			
24. FUNERAL DIRECTOR Rest Haven Funeral Chapel Hagerstown, Md.					25a. REC'D BY REGISTRAR DATE DEC 23 1968			25b. REGISTRAR'S SIGNATURE William E. Under			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

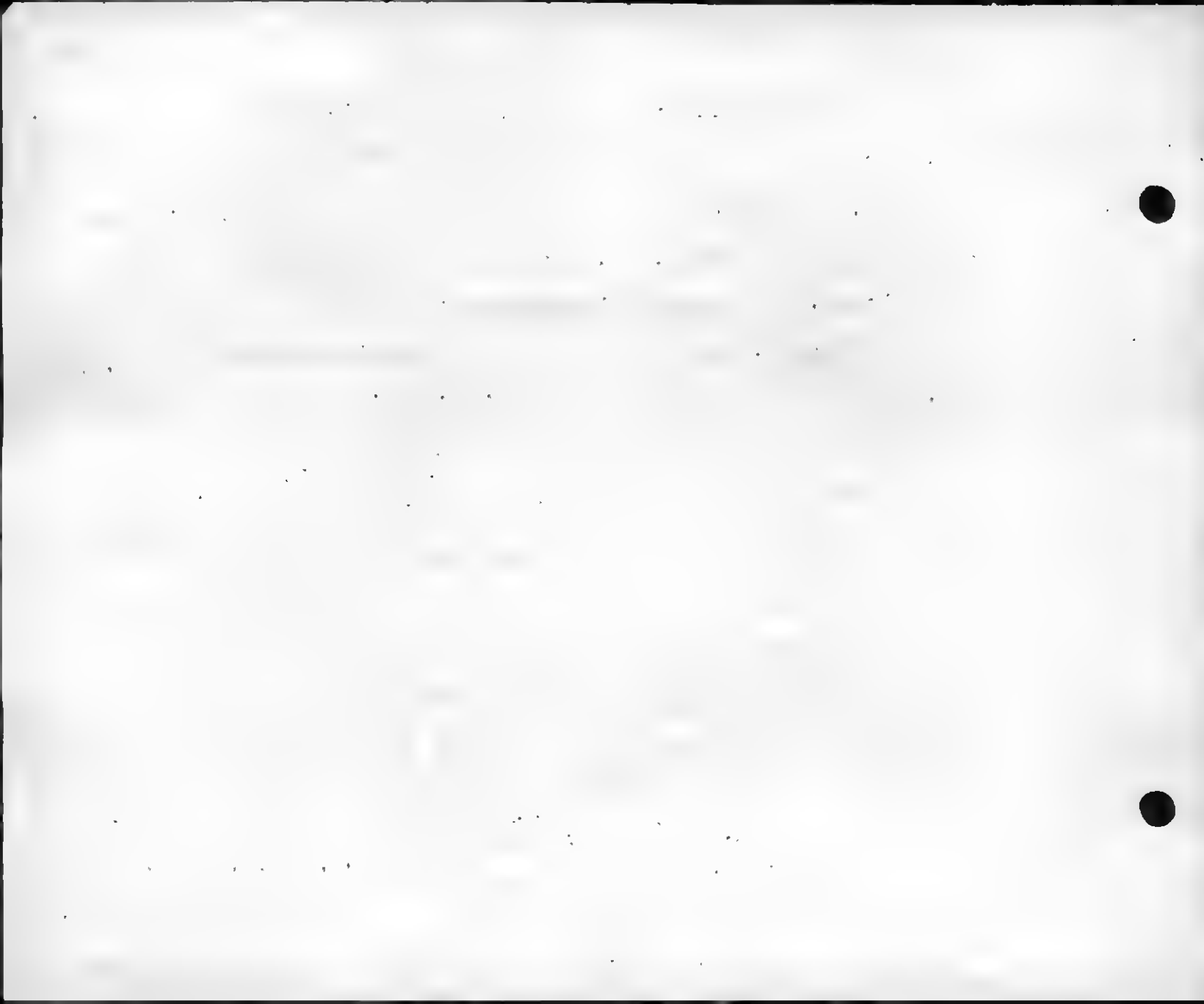
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 8 Filed 04/07 12/21/68
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18425

1 DECEASED-NAME (Type or print) Alice Marguerite Spangler			2a. DATE OF DEATH Month December Day 3 , Year 1968			2b. HOUR 8:58 A. M.	
3 SEX female		4. RACE white		5. DATE OF BIRTH May 5, 1889		6. AGE (In years last birthday) 79 YRS.	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Penna.		13b. COUNTY Fulton		13c. CITY OR TOWN McConnellsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last George W. Hays		15. MOTHER'S MAIDEN NAME First Middle Last Virginia Michaels					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Mary E. Helleman, McConnellsburg, Penna.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11/17, 1948 to 12/3, 1968 , that (I) (we) last saw the deceased alive on 12/2/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edson B. Moody		22c. DATE SIGNED 12/9/68		22d. PHYSICIAN'S NAME (Type) Edson B. Moody			
22e. ADDRESS 363 Cleveland Ave., Hag., Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 12-5-68		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City or Town) (County) (State) McConnellsburg, Penna.	
24. FUNERAL DIRECTOR Kelso Funeral Home, McConnellsburg, Pa				25a. REC'D BY REGISTRAR DEC 9 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First LORENA		Middle C.		Last STEIGER		2a. DATE OF DEATH Month Day Year Dec. 12, 1968			2b. HOUR A 3:30 PM
3. SEX Female		4. RACE White		5. DATE OF BIRTH Apr. 16, 1899			6. AGE (In years last birthday) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Franklin Co. Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md					
10. CITY OR TOWN OF DEATH Hagerstown, R.D.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Avalon Manor		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Store clerk			12b. KIND OF BUSINESS OR INDUSTRY Apparel				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 112 S. Prospect			
14. FATHER'S NAME First Middle Last George S. Cover				15. MOTHER'S MAIDEN NAME First Middle Last Mary Catherine Narcleroad							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16b. SOCIAL SECURITY NO 203-10-6498		17. INFORMANT 4611 Guilford Rd. Ralph D. Myers College Park, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic carcinoma, abdominal</i> <i>1530</i> DUE TO, OR AS A CONSEQUENCE OF <i>probably from colon</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? 6 mo -	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>1538</i> <i>Exploratory laparotomy 10/4/68</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>10-17, 1968</i> , to <i>12-12, 1968</i> , that (I) (we) last saw the deceased alive on <i>11/21/1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John H. Hornbaker M.D.</i>						DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>12-13-1968</i>	
22d. PHYSICIAN'S NAME (Type) JOHN H. HORNBAKER, M.D.						22e. ADDRESS <i>154 West Washington St., Hagerstown, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/15/68		23c. NAME OF CEMETERY OR CREMATORY Fairview Cem.			23d. LOCATION (City or Town) (County) (State) Mercersburg Franklin Pa.				
24. FUNERAL DIRECTOR <i>J.H. Sminger, Mercersburg, Pa.</i>				ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 17 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
ELIZABETH YOCOM STICKNEY						DECEMBER 11 1968			9 aM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE		WHITE		DECEMBER 11, 1902			65 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY				
NEW YORK		U.S.A.				WASHINGTON			GAS COMPANY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
HAGERSTOWN			1704 C'EST DRIVE			SECRETARY							
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND			WASHINGTON			HAGERSTOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1704 C'EST DRIVE			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last									
WILLIAM HOWARD MERSEBAU				ELIZABETH YOCOM									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			1704 Address C'EST DR.				
NO			136-26-8291			MRS. WARREN JOHNSON HAGERSTOWN, MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) subarachnoid Hemorrhage										45 min			
4309 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
(b) Arteriosclerotic Vasc. Disease													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
230X													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Feb 8, 1963, to Dec 11, 1968, that (I) (we) last saw the deceased alive on Dec 11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE								DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
LLOYD A. HOFFMAN												12/12/68	
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS					
LLOYD A. HOFFMAN, M.D.								214 N POTOMAC ST., HAGERSTOWN, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
CREMATION			12/14/68			ROSE HILL CEMETERY			HAGERSTOWN UNION NEW J.				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Charles M. Langer			HAGERSTOWN, MARYLAND			DATE DEC 16 1968			Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

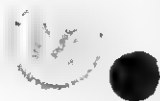
CERTIFICATE OF DEATH

18428

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M	
Karl			Oliver	Stoner	December 20 1968					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Male		White		July 1, 1909		59 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Hagerstown, Md.		USA				Washington Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			21 S. Potomac St.			Sheet Metal			Aircraft	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
STATE Maryland			Washington					21 S. Potomac St.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Arthur Jacob Stoner			Annie Agnes Keedy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address				
No			214-09-2343			Mrs. K.O. Stoner 21 S. Potomac St. Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia (Probable)										minutes
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease										years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION										
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										
21d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										
21f. LOCATION Street or RFD No City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from Jan, 1968, to Dec, 1968, that (I) (we) last saw the deceased alive on Dec 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE Charles C. Spencer DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										
22c. DATE SIGNED 12-23-68										
22d. PHYSICIAN'S NAME (Type) Charles C. Spencer 22e. ADDRESS 220 145 S. Prospect St. Hagerstown Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										
23b. DATE 12/23/68										
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery										
23d. LOCATION (City or Town) (County) (State) Hagerstown-Washington-Md										
24. FUNERAL DIRECTOR Wm. C. Ford ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.										
25a. REC'D BY REGISTRAR DATE DEC 27 1968										
25b. REGISTRAR'S SIGNATURE J. Charles Judge										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

184118

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18429

1 DECEASED-NAME (Type or Print)		First	Middle	LAST	2a DATE KNOWN OF ESTI- DEATH MATED		Month	Day	Year	2b HOUR
JOHN		EDWARD	STONESIFER				12	31	1968	M
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (n years last birthday)	7 UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	2c DATE PRONOUNCED DEAD Month		Day	Year
Male	White	1-11-1906		62 YRS			December		31	1968
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		12b KND OF BUSINESS OR INDUSTRY		
Carroll Co		U.S.A.				Washington		W.M. RR		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KND OF BUSINESS OR INDUSTRY		
Hagerstown		Washington Co. Hospital				Trackman				
13a USUAL RESIDENCE (Where deceased lived, if admission)		13b CITY OR TOWN		13c INSIDE CITY LIMITS?		13d STREET AND NUMBER				
Maryland		Corroll		Tannytown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.D.2		
14. FATHER'S NAME		First	Middle	LAST	15 MOTHER'S MAIDEN NAME		First	Middle	LAST	
John A. Stonesifer					Minnie Fleagle					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		RD2		
		705-10-5297		Elenora K. Stonesifer		Tannytown Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerosis coronary artery</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Heart</u> 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>small</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (At home, farm, street factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASS STANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		Howard N. Weeks		Thurmont, Md.		WASHINGTON COUNTY		1/1/69		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
Burial		1-3-69		Keesville, Cemetery		Keesville, Maryland.				
24 FUNERAL DIRECTOR		Raymond		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Raymond F. Brager		Thurmont, Md.		DATE		JAN 6 1969		Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

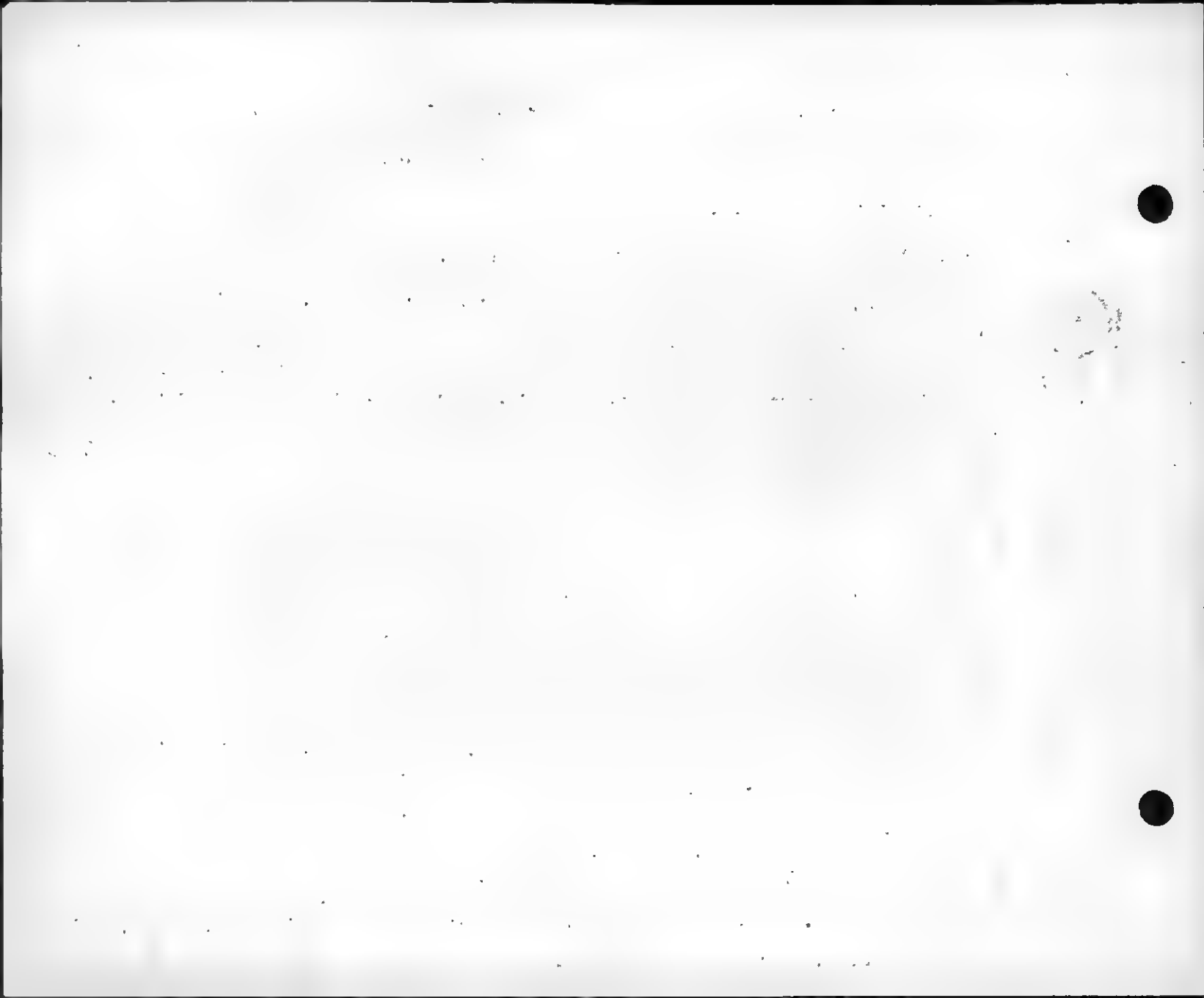
CERTIFICATE OF DEATH

18430

1. DECEASED NAME (Type or print) First <u>Ralph</u> Middle <u>J</u> Last <u>Stottlemeyer</u>			2a. DATE OF DEATH Month <u>Dec.</u> Day <u>12</u> Year <u>1968</u>		2b. HOUR <u> </u> MIN <u> </u>
3. SEX <u>Male</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>Jan 24 1897</u>		6. AGE (In years last birthday) <u>71</u> YRS.	IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>
7a. BIRTHPLACE (State or foreign country) <u>Indiana</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <u>Washington</u>			Md		
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington County Hosp.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u> </u>	
12b. KIND OF BUSINESS OR INDUSTRY <u> </u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Washington</u>		13c. CITY OR TOWN <u>Hagerstown</u>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>808 Washington Ave.</u>			
14. FATHER'S NAME First <u>Rufus</u> Middle <u> </u> Last <u>Stottlemeyer</u>			15. MOTHER'S MAIDEN NAME First <u>Pearl</u> Middle <u>Wetghet</u> Last <u> </u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u> (If yes give war or dates of service) <u> </u>		16b. SOCIAL SECURITY NO. <u>216-22-2021</u>		17. INFORMANT <u>808 Washington Ave.</u> <u>Mrs. Kenneth Dennis Hagerstown Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Agnogenic Myeloid sclerosis</u> <u>75</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>2, 8, 1</u> (b) <u> </u> DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 mo.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Leomyosarcoma - small bowel</u>					
19a. DATE OF OPERATION <u>Dec. 7th</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Splenomegaly</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u> </u>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u> P.M. <u> </u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) <u> </u>			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u> </u>		21f. LOCATION Street or R.F.D. No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>	
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>64</u> , to <u>Dec. 12</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 12</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Carol A. Hoffman</u> DEGREE <u> </u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>12/13/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>Carol A. Hoffman</u>		22e. ADDRESS <u>2104 N. Patomac St.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 15-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	
23d. LOCATION (City or Town) <u>Williamsport Wash. Md.</u>		(County) <u> </u> (State) <u> </u>			
24. FUNERAL DIRECTOR <u>Mr. Albert L. Leaf Williamsport Md.</u>			25a. REC'D BY REGISTRAR DATE <u>DEC 16 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR A15 (4)
30M REV. 11-65

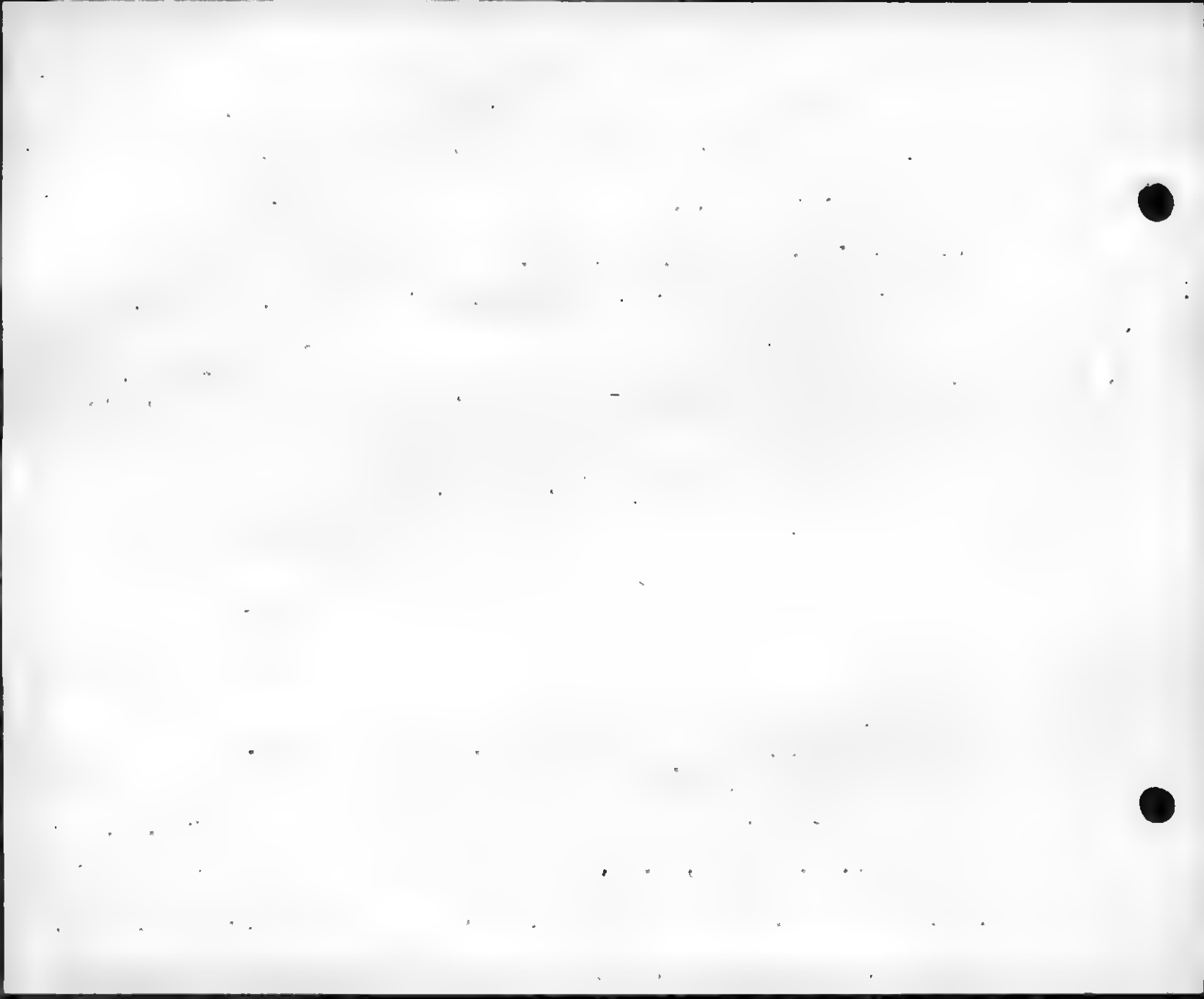
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18418

18431

1 DECEASED-NAME (Type or print) George		First W.	Middle Strain	Last	2a DATE OF DEATH Dec. 9 1968	2b HOUR M
3 SEX Male	4 RACE Colored	5 DATE OF BIRTH March 14 1893		6 AGE (In years last birthday) 75 YRS.	IF UNDER 1 YEAR 8 MONTHS 25 DAYS	IF UNDER 24 HRS 25 HOURS MIN
7a BIRTHPLACE (State or foreign country) North Carolina	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington		Md	
10 CITY OR TOWN OF DEATH Williamsport Md.	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 43 E. Church St.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer		12b KIND OF BUSINESS OR INDUSTRY Brick Yard	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b COUNTY Washington	13c CITY OR TOWN Williamsport	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 43 E. Church St.		
14 FATHER'S NAME First Unknown		Middle	Last	15 MOTHER'S MAIDEN NAME First Unknown		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (If yes, give war or dates of service) World War I		16b SOCIAL SECURITY NO. 216-07-6993	17 INFORMANT 43 E Church St. Mrs. Arlene Strain Williamsport, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 mins ± 10 yrs						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4101 none						
19a DATE OF OPERATION 4-11-68		19b CONDITION FOR WHICH OPERATION WAS PERFORMED none		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY 19 HOUR A.M. Month 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (the physician) attended the deceased from Aug. 19 1958 , to Nov. 8 1968 , that (I) (we) last saw the deceased alive on Dec. 9 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death.						
22b SIGNATURE M. E. Byrkit				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED Dec. 9, 1968
22d. PHYSICIAN'S NAME (Type) M. E. Byrkit, M. D.				22e ADDRESS Williamsport, Maryland 21795		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE Dec. 12-68	23c NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d LOCATION (City or Town) (County) (State) Williamsport Wash. Md.		
24 FUNERAL DIRECTOR Albert L. Leaf Williamsport Md.				25a. REC'D BY REGISTRAR DEC 12 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF EST DEATH			2b HOUR		
William Zabeau Sullivan						Month Day Year			12 17 1967		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d HOUR		
Male	White	Jan 21 1930	38 YRS	MONTHS	DAYS	Month Day Year			12 17 1967		
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH			Md.		
Sisterville		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Washington					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington County Hospital			Pharmacist			Drug Store		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Maryland			Washington			Williamsport			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER			14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?		
136 E. Potomac St.			First Middle Last			First Middle Last			16b SOCIAL SECURITY NO		
			Michael J Sullivan			Bertha M Zabeau			188-22-0286		
17 INFORMANT			18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Mrs. Sue Ann Sullivan			PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			Approx.					
196 E. Potomac St. Williamsport, Md.			4. x DUE TO, OR AS A CONSEQUENCE OF			4-6 days					
			(b) Acute lobar pneumonia involving both lungs								
			DUE TO OR AS A CONSEQUENCE OF								
			(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4. ?											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH			19 P.M.								
21d INJURY OCCURRED			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town County State		
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASS STANT MEDICAL EXAMINER			22b DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			227 W. Washington St. Hagerstown, Md.		
Edward W. Ditto, III, M.D.											
23a BURIAL, CREMATION, REMOVAL			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			Dec. 20-68			Greenlawn Cemetery			Williamsport Wash. Md.		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
Albert L. Leaf Williamsport, Md.						DEC 23 1968					

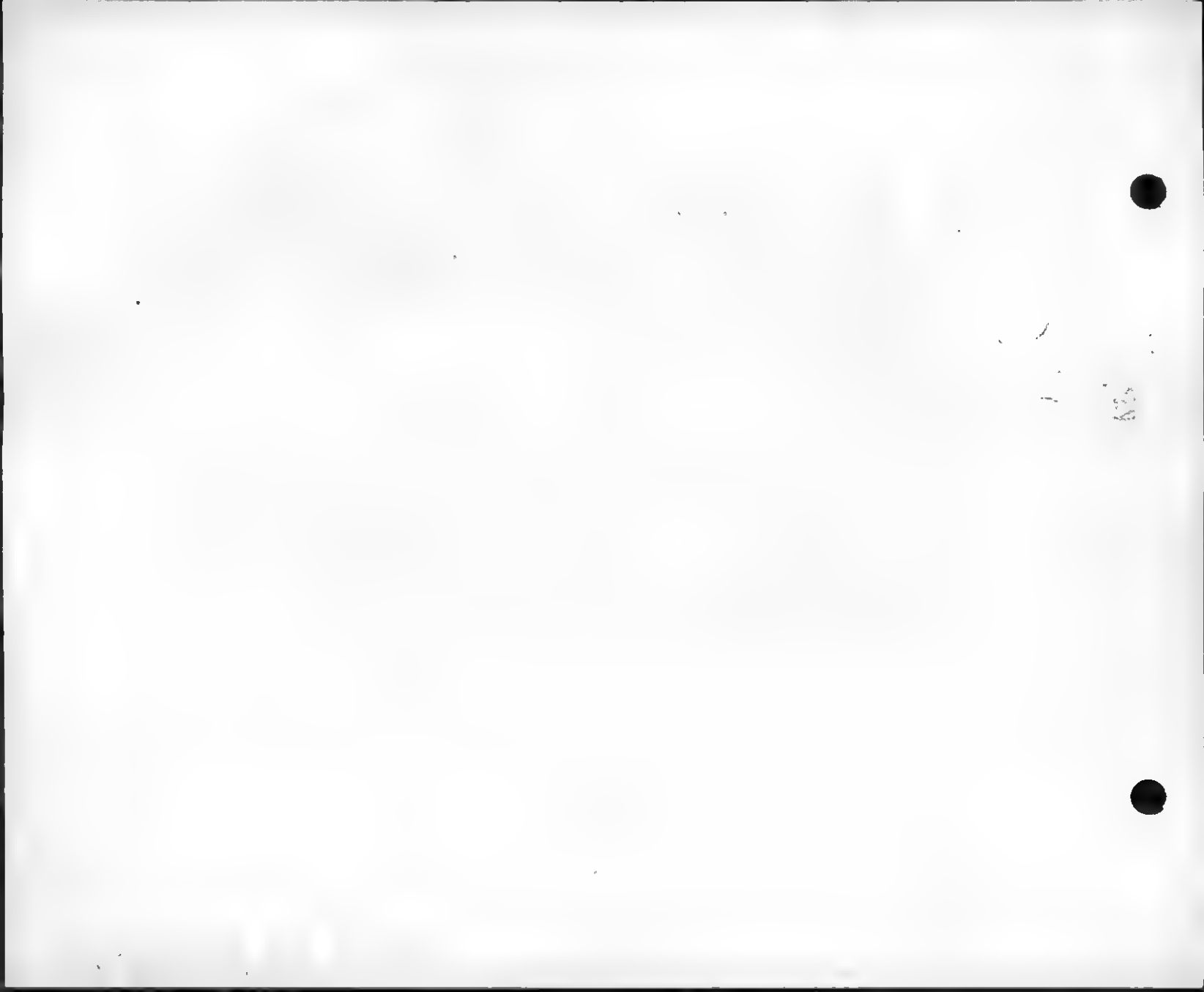


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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18420										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										18433									
1										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First MIDDLE Last					2a. DATE OF DEATH					2b. HOUR														
NETTIE					ARBELLA					SWOPE					DECEMBER Month 14 Day 68 Year					M									
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
FEMALE					WHITE					OCTOBER 6, 1893					75 YRS.														
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH					Md.									
MARYLAND					U.S.A.										WASHINGTON														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY														
HAGERSTOWN					WASHINGTON COUNTY HOSP.					HOMEMAKER					OWN HOME														
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
MARYLAND					WASHINGTON					HAGERSTOWN					YES <input type="checkbox"/> NO <input type="checkbox"/>					848 MARSHALL ST.									
14. FATHER'S NAME					First MIDDLE Last					15. MOTHER'S MAIDEN NAME					First MIDDLE Last														
SAMUEL					OLIVER SPESSARD					EMMA					SHANK														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO					17. INFORMANT					848 Address					MARSHALL ST.									
NO										MR. CHARLES V SWOPE					HAGERSTOWN, MARYLAND														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of liver & local spread.</u>															6 mos														
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1561</u>																													
DUE TO, OR AS A CONSEQUENCE OF																													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																													
<u>Jaundice (obstructive)</u>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year					21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																			
					P.M. 19																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (the hospital) attended the deceased from <u>23 Jan 1968</u> to <u>14 Dec 1968</u> , that (I) (we) last saw the deceased alive on <u>13 Dec 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Richard T Binford</u>															22c. DATE SIGNED <u>12/16/68</u>														
22d. PHYSICIAN'S NAME (Type) <u>RICHARD T BINFORD, M.D.</u>															22e. ADDRESS <u>1135 POTOMAC AVE., HAGERSTOWN, MD.</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
BURIAL					12/17/68					REST HAVEN CEMETERY					HAGERSTOWN, WASHINGTON, MD.														
24. FUNERAL DIRECTOR ADDRESS <u>Charles M. Rouzer</u> HAGERSTOWN, MARYLAND															25a. REC'D BY REGISTRAR DATE <u>DEC 20 1968</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18434

1. DECEASED-NAME (Type or print) First Middle Last LUCIAN TERRY THOMAS			2a. DATE OF DEATH Month 3 Day 68 Year DECEMBER		2b. HOUR 4:30am
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH AUGUST 31, 1898		6. AGE (in years last birthday) 70 YRS.	7. UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON Md.		
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON COUNTY HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED SALEMAN	12b. KIND OF BUSINESS OR INDUSTRY PLUMBING SUPPLIES
13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY WASHINGTON	13c. CITY OR TOWN HAGERSTOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 831 WOODLAND DR
14. FATHER'S NAME First Middle Last WILBUR THOMAS		15. MOTHER'S MAIDEN NAME First Middle Last BLANCHE MITCHELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 229-10-3741		17. INFORMANT MRS GLADYS THOMAS 831 Address WOODLAND HAGERSTOWN, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 41-1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4207 (b) atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus & diabetic acidosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days year
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Nov. 30, 1968 to Dec. 3, 1968, that (I) (we) last saw the deceased alive on December 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edson B. Moody		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/3/68	
22d. PHYSICIAN'S NAME (Type) EDSON B. MOODY, M.D.		22e. ADDRESS 363 CLEVELAND AVE., HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12/5/68		23c. NAME OF CEMETERY OR CREMATORY RIVERVIEW CEMETERY	
23d. LOCATION (City or Town) (County) (State) RICHMOND VIRGINIA		23e. REC'D BY REG. STRAR DEC 6 1968			
24. FUNERAL DIRECTOR Charles M. Rouger		ADDRESS HAGERSTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR M
CLYDE OLIVER TRUMPOWER, SR.						Dec. 14 1968			
3. SEX	4. RACE	5. DATE OF BIRTH				6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Male	White	May 1, 1888				80			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH			
Maryland	U. S. A.					Washington Md.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown	Wash. County Hospital				Machinist			retired	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Res. since before admission) STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER			
Maryland		Washington	Hagerstown		Sharpshurg Pike				
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Joseph Trumpower			Catherine - Atherton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
no --		220-10-3719		Edward Trumpower, 23 Lehigh Ave. Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cerebral thrombosis									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Senile arteriosclerosis									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12/13/68 to 12/14/68, that (I) (we) last saw the deceased alive on 12/14/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Donald E. Martin, M.D.					22c. DATE SIGNED 12/16/68				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS 363 S. Cleveland Ave., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		12/17/68	Rest Haven Cemetery			Hagerstown, Wash. Md.			
24. FUNERAL DIRECTOR Hagerstown, Md. Andrew K. Coffman Funeral Home, Inc.					25a. REC'D BY REGISTRAR DATE DEC 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

I have been thinking of you very much lately.

I hope you are well and happy.

I have been very busy lately.

I have been thinking of you very much lately.

I hope you are well and happy.

I have been very busy lately.

I have been thinking of you very much lately.

I hope you are well and happy.

I have been very busy lately.

I have been thinking of you very much lately.

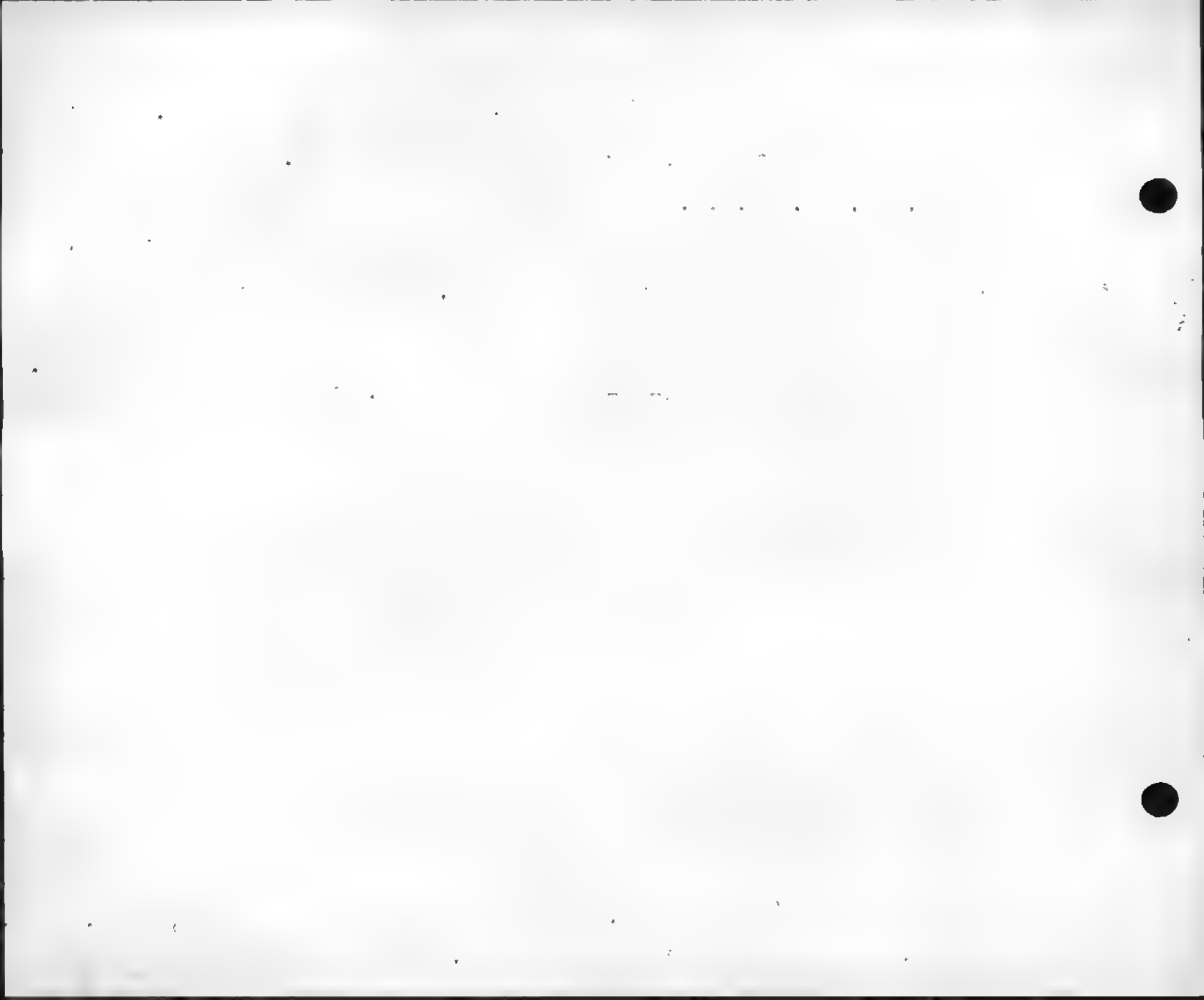
I hope you are well and happy.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Ernest			Middle #			Last Trumpower		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years and birthday)	7 UNDER 1 YEAR	8 UNDER 24 HRS	2a DATE KNOWN OF DEATH			2b HOUR		
Male	White	July 18, 1912	56 YRS	MONTHS	DAYS	Dec. 28 1968			1:50 M		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			2c DATE PRONOUNCED DEAD		
Wash. Co., Md.		U.S.A.				Washington Md			Dec. 28 1968 M		
1d. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Clear Spring			None			Farmer			Farming		
13a USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission to hospital)			13b CITY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Maryland			Washington			Clear Spr.			None		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
David # Trumpower			Grace # Slayman								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS					
No			None			Mildred L. Trumpower Clear Spring Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolus											
4 x DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
465x											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			2d AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED					
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			12/30/68					
Howard N. Weeks			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Washington					
ADDRESS			ADDRESS (Street, city, town, or county)								
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c. NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			12/31/68			St. Pauls Cemetery			Clear Spring, Wash. Md		
24 FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE					
Margaret Rowland			Clear Spring, Md.			JAN 2 1969 Charles Judge					



FOR STATE HEALTH DEPT.

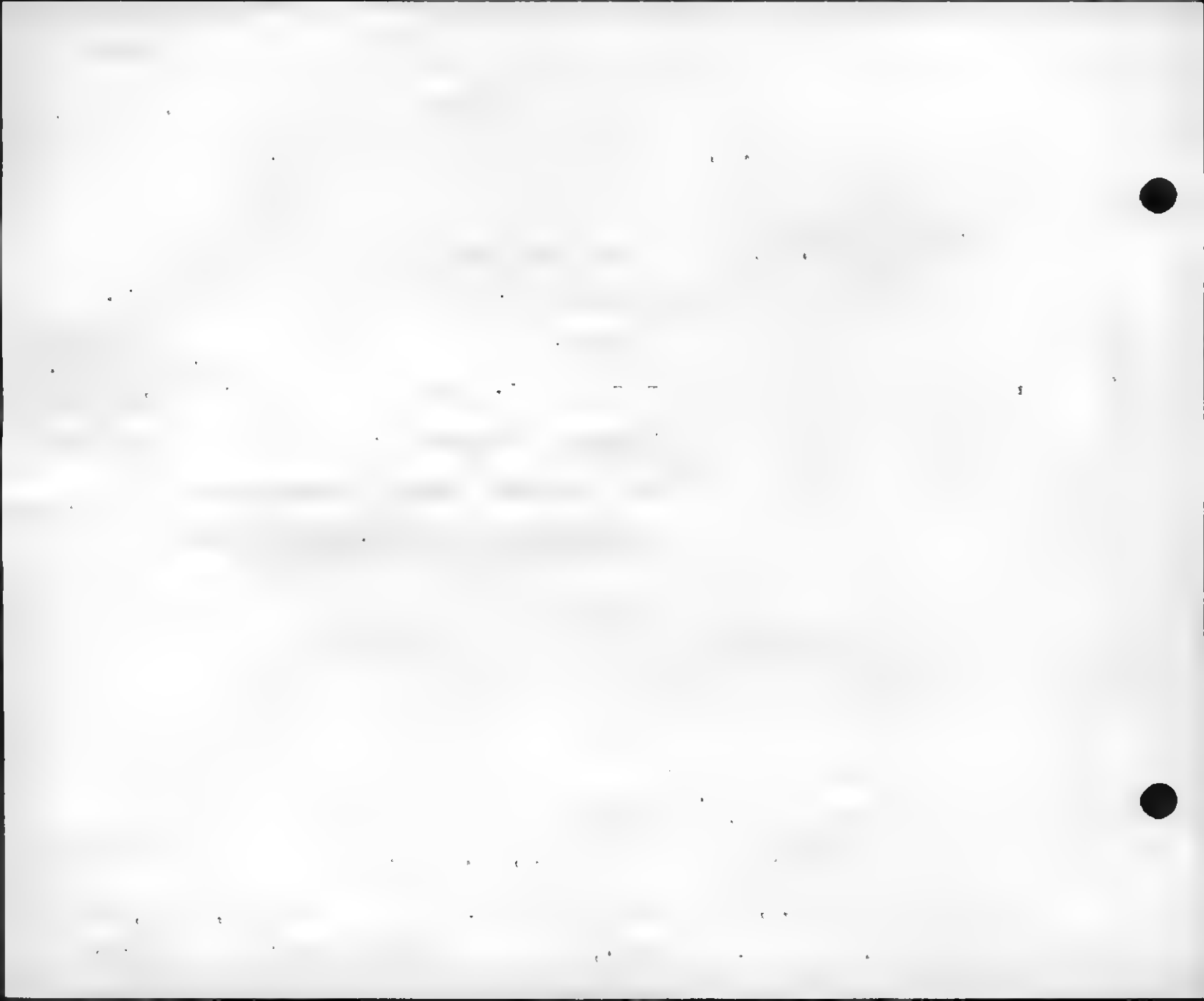
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18437

1. DECEASED NAME (Type or Print) Garnett Walter Trumpower			2a. DATE KNOWN OF EST- DEATH MATED <input checked="" type="checkbox"/> Dec. 6, 1968			2b. HOUR 1:45 PM			
3. SEX Male	4. RACE White	5. DATE OF BIRTH Feb. 3, 1897	6. AGE (in years and birthday) 71 YRS MONTHS 10 DAYS 3	7. UNDER 24 HRS HOURS 3 MIN 0		2c. DATE PRONOUNCED DEAD Month Dec Day 6 Year 1968			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington			
10. CITY OR TOWN OF DEATH Beaver Creek District Near Hagerstown, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Off Cool Hollow Road			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Sheet Metal Worker		12b. KIND OF BUSINESS OR INDUSTRY Aircraft		
13a. USUAL RESIDENCE (Where deceased lived, first full on admission) Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1925 Lexington Ave.	
14. FATHER'S NAME First Frank Middle Trumpower Last Trumpower			15. MOTHER'S MAIDEN NAME First Mina Middle Bridendolph Last Bridendolph			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			
16b. SOCIAL SECURITY NO. 214-09-6703		17. INFORMANT Mrs. Dorothy Trumpower Hagerstown, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. ADJUSTMENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Edward W. Ditto III			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 12-8-68			
EXAMINER'S NAME (Type) Edward W. Ditto III Hagerstown, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Dec. 9, 1968		23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d. LOCATION (City or Town) (County) (State) Williamsport, Wash., Maryland		
24. FUNERAL DIRECTOR Albert L. Leaf			ADDRESS Williamsport, Maryland.			25a. REC'D BY REGISTRAR DEC 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

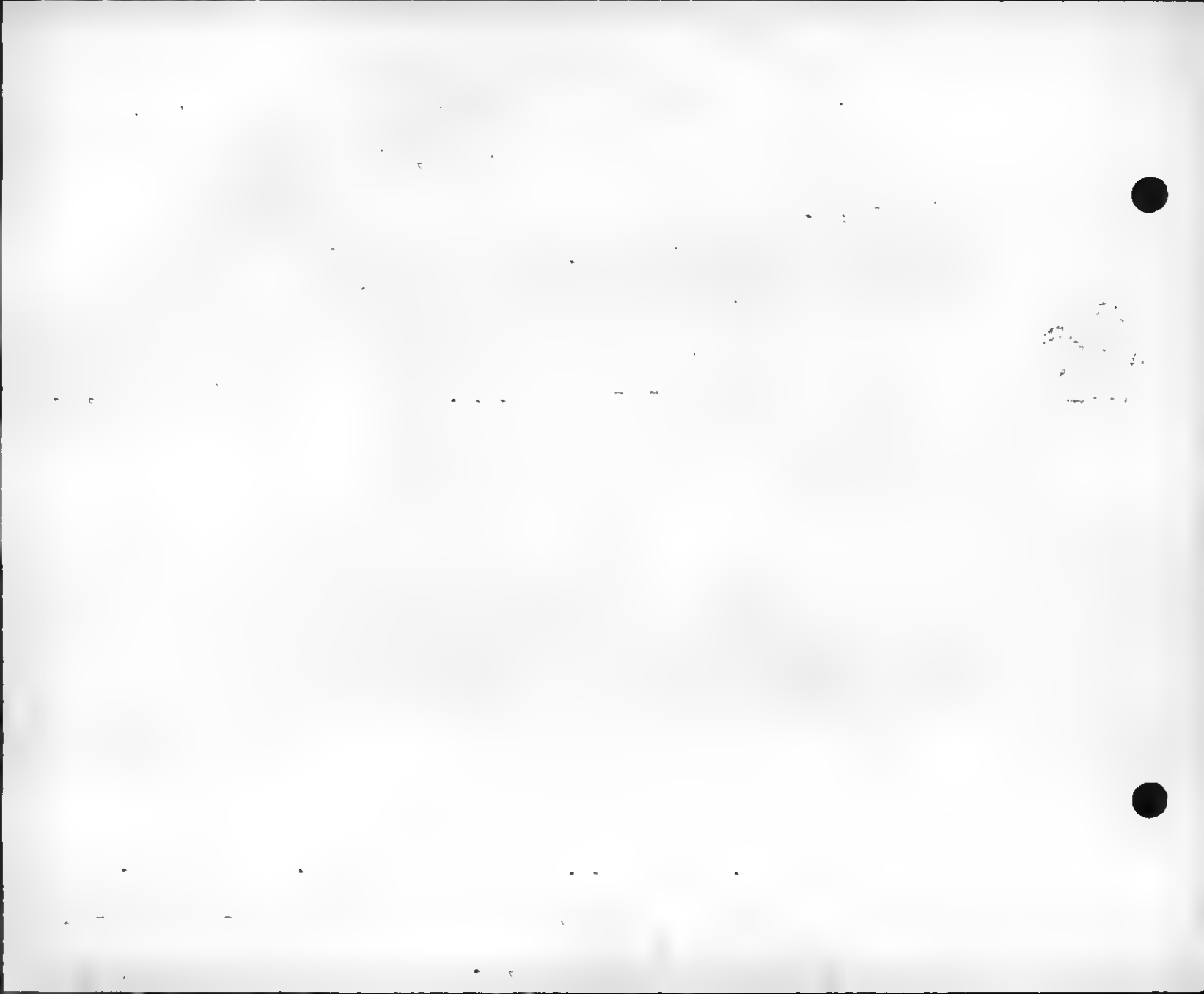


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1 DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
				William	Woodrow	Trumpower	December 11 1968			M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (n years lost birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.
Male		White		July 28, 1914		54 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Williamsport, Md.		USA				Washington		Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown		Washington Co. Hospital DCA		Machinist		Railroad				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		Washington		Williamsport		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R # 1		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		
James Vernon Trumpower		May Lula Guessford		No		705-10-4685		Mrs. W.W. Trumpower R # 1 Williamsport, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>										minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u>										indefinite
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>1953</u> to <u>12-7-1968</u> , that (I) last saw the deceased alive on <u>12-7-68</u> , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
Robert J. Keadle		12-11-68		M.D.		580 Northern Ave. Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		12/14/68		Rest Haven Cemetery		Hagerstown-Washington-Md.				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE				
Wm. C. Ford		DEC 16 1968		f Charles Judge						
Rest Haven Funeral Chapel Hagerstown, Md.										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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WAGNER

18439

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18439

1. DECEASED-NAME (Type or print) Stephen Michael Wagner		2a. DATE OF DEATH Month 12 Day 24 Year 68		2b. HOUR 3:40 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH 12-23-68		6. AGE (In years last birthday) YRS. 1 MONTHS 1 DAYS 1
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington Md.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None	12b. KIND OF BUSINESS OR INDUSTRY Infant	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Camp Ritchie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET AND NUMBER Bldg 462 Apt A.	
14. FATHER'S NAME First Middle Last John Emanuel Wagner	15. MOTHER'S MAIDEN NAME First Middle Last Ermgard Louise Weikard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) --	16b. SOCIAL SECURITY NO None	17. INFORMANT John E. Wagner IV Bldg 462		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Distress Syndrome DUE TO, OR AS A CONSEQUENCE OF (b) Hyaline Membrane Disease DUE TO, OR AS A CONSEQUENCE OF (c) 77735 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 77735				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Prematurity				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 23 Dec , 19 68 , to 24 Dec , 19 68 , that (I) (we) last saw the deceased alive on 24 Dec , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Ronald E. Keyser	DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 24 Dec 68		
22d. PHYSICIAN'S NAME (Type) Ronald E. Keyser	22e. ADDRESS 119 King St. Hagerstown Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/26/68	23c. NAME OF CEMETERY OR CREMATORY Sunset Cemetery	23d. LOCATION (City or Town) (County) (State) Clarksburg Harrison Co. W. Va.	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc	ADDRESS Hagerstown Md.	25a. REC'D BY REG. STRAR DEC 27 1968	25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-10
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18427

18440

1. DECEASED-NAME (Type or print) Edgar M. Weber			2a. DATE OF DEATH Dec. 3, 1968			2b. HOUR 11:45 P.			
3. SEX Male		4. RACE white		5. DATE OF BIRTH 5-30-1899		6. AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Wash. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired farmer		12b. KIND OF BUSINESS OR INDUSTRY Farm			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Smithsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rd. 2 Smithsburg, Md.	
14. FATHER'S NAME Benjamin Weber			15. MOTHER'S MAIDEN NAME Anna (Martin) Weber						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year and dates of service)		16b. SOCIAL SECURITY NO. 217-42-9253		17. INFORMANT Mrs. Edna Weber - Smithsburg, Md.		Address Rd. 2 Smithsburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 1890 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 180 X (b) Meloidic Ca of Lung DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of @ Kidney								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs 3 mo 6 mo	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Atherosclerotic Heart Disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 68 , 19 68 , to Dec 3 , 19 68 , that (I) (we) last saw the deceased alive on Dec 3 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Donald E. Martin				22c. DATE SIGNED 12/4/68					
22d. PHYSICIAN'S NAME (Type) DR. DONALD E. MARTIN				22e. ADDRESS Cleveland - Cannon Ave - Hagerstown, Md.					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 12/7/68		23c. NAME OF CEMETERY OR CREMATORY Ruff Ch. Cem.		23d. LOCATION (City or Town) (County) (State) Clearfoss, Md.			
24. FUNERAL DIRECTOR A.E. Munnich - Greencastle, Pa.				25a. REC'D BY REGISTRAR DEC 6 1968		25b. REGISTRAR'S SIGNATURE Charles Yunge			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. DECEASED-NAME (Type or print) First Middle Last Cora Irene Zimmerman						2a. DATE OF DEATH December 14, 1968			2b. HOUR M			
3. SEX female		4. RACE white		5. DATE OF BIRTH 11-13-1882			6. AGE (In years last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.						
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 811 S. Potomac, St.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 811 S. Potomac, St.			
14. FATHER'S NAME First Middle Last Luther M. Zimmerman				15. MOTHER'S MAIDEN NAME First Middle Last Louisa Saltsgiver								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no				16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Adelbert Burton Hagerstown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 4310 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs years years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 331X												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from Dec 17, 1968, to Dec 14, 1968, that (I) (we) lost the deceased alive on 13 Dec 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Charles Hoochlander M.D. 22d. PHYSICIAN'S NAME (Type) Elder S Hoochlander						22c. DATE SIGNED 12/16/68		22e. ADDRESS Hagerstown Md		22f. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-16-68		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.				
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home Hagerstown, Md.						25a. REC'D BY REGISTRAR DATE DEC 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

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